

Application

**Regional Med Extended Care Hospital,
LLC dba Regional One Health Extended
Care Hospital**

CN1708-025



State of Tennessee

Health Services and Development Agency

Andrew Jackson Building, 9th Floor, 502 Deadrick Street, Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Regional Med Extended Care Hospital, LLC, dba Regional One Health Extended Care Hospital
Name

890 Madison Avenue, 4th Floor
Street or Route

Shelby
County

Memphis
City

TN
State

38103
Zip Code

Website address: https://www.regionalonehealth.org/extended-care-hospital/

Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr.
Name

Attorney
Title

Anderson and Baker
Company Name

graham@grahambaker.net
Email address

2120 Richard Jones Road
Street or Route

Nashville
City

TN
State

37215
Zip Code

Attorney
Association with Owner

615-370-3380
Phone Number

615-221-0080
Fax Number

NOTE: *Section A* is intended to give the applicant an opportunity to describe the project. *Section B* addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on 8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

- 1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital (“Applicant”), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, a licensed twenty-four (24) bed hospital providing Long Term Acute Care Hospital (“LTACH”) services, owned by Shelby County Health Care Corporation, with the Applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, and to be managed by Murer Consultants, Inc., 19065 Hickory Creek Drive, Suite 115, Mokena, IL 60448, intends to file a Certificate of Need application for the addition of six (6) hospital beds limited to LTACH services. The requested six (6) additional beds will be housed on the 2nd floor of the existing building, and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately \$2,215,000.00, including a \$15,000.00 filing fee.

The anticipated date of filing the application is: August 15, 2017.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

Neither the Applicant nor its owner have any outstanding Certificate of Need applications that are approved but not yet in service.

- 2) Ownership structure;

Response: Regional Med Extended Care Hospital, LLC (“Applicant”), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, is owned by Shelby County Health Care Corporation.

- 3) Service area;

Response: As the service being provided is very specialized, patients originate from a wide geographic area. The facility’s existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant’s patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant.

- 4) Existing similar service providers;

Response: There are now only three (3) LTACH providers in Memphis, including:

30 beds at Baptist Memorial Restorative Care Hospital;
39 beds at Select Specialty Hospital (located within St. Francis Hospital); and
24 beds at the Applicant's facility (historically, staffed for only 21 beds).

The 36 beds at Methodist have closed, and the Applicant receives patient referrals from Methodist hospital now.

- 5) Project cost;

Response: The estimated project cost is anticipated to be approximately \$2,215,000.00, including filing fee. The vast majority of these costs involve ongoing lease costs. Very little "new" resources are required for this project.

- 6) Funding;

Response: There is no construction, and minimal "renovation," which entails the hanging of a sign indicating where the Applicant's beds will be on the 2nd Floor.

- 7) Financial Feasibility including when the proposal will realize a positive financial margin;
and

Response: Based on the Year 1 budget projections, and assuming the project is approved and is initiated within the timeframe as indicated, the long term acute care hospital is anticipated to realize a positive cash flow in the first year following completion of the addition. We believe the additional beds will fill up almost immediately.

8) Staffing.

Response: The LTACH is currently staffed for 21 beds. The below demonstrates the staffing model for both existing and for 30 beds.

Position Classification	Existing FTE 2017	Projected FTE (Year 1)	Avg Wage \$ (contractual rate)	Avg Wage \$ Area/State
RN	38.0	53.3	32.71	31.75
CNA	9.9	10.1	13.23	12.95
Patient Care Extern	0.4	0.5	18.69	31.75
Dir. Respiratory Care	1.0	1.0	42.52	31.75
Liaison Nurse	2.0	2.0	34.88	31.75
Lead Respiratory Therapist	1.2	1.0	29.42	31.75
Occupational Therapist	0.9	0.8	47.67	31.75
Physical Therapist	0.9	0.9	48.18	31.75
Speech Pathologist	0.9	1.0	47.44	31.75
Patient Care Coordinator	4.0	3.5	30.35	31.75
Resp Ther/RRT	9.9	10.2	24.19	31.75
Medical Assistant	2.0	2.0	13.91	12.95
Physical Ther Asst	1.1	1.1	29.88	31.75
Resp Ther Tech/Cert	1.0	1.0	23.74	31.75
Patient Serv Clerk	5.6	5.5	14.57	12.95
a. Total Direct Care	78.7	93.8		
Nursing Clin Supv	0.6	1.0	45.67	43.95
Chief Nursing Officer	1.0	1.0	58.85	43.95
Dir HIM	1.0	1.0	37.02	43.95
Case Mgr/RN	1.0	1.1	33.97	43.95
HIM Coding Spec	0.4	0.1	22.00	12.95
Admitting Coordinator	1.0	1.0	19.85	12.95
Pre-Certification Nurse	0.9	1.9	33.65	12.95
CMS Data Coordinator	0.9	1.0	19.31	12.95
Admin Secretary	0.2	0.0	16.50	12.95
b. Total Non-Direct	6.9	8.1		
Contracted Therapy				
Contracted Med Dir/Diet.				
c. Total Contractual	0.0	0.0		
Total Staff (a + b + c)	85.6	101.9		

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: The addition of six (6) beds, within a physical space layout that provides for more efficient care coordination for the hospital and patients, will permit greater access to care for this highly acute patient population with a need for an extended, acute care stay.

Being part of a health care organization that serves as a Level One Trauma Center and Regional Burn Center, Regional One Health has a need for long term acute care services within its post-acute complement. Patients with extended care needs related to ventilator management and weaning are best served in the long term care environment; with Regional One Health Extended Care Hospital demonstrating vent weaning well below the national average.

Also, Methodist Hospital closed its 36 bed LTACH recently and now refers their long term care hospital patients to the Applicant. Since the HSDA originally approved that facility, it follows that the need for the six (6) beds requested in the instant application has already been positively addressed. This is especially true since Select Specialty Hospital, another LTACH in Memphis, recently (July 10, 2017) voluntarily surrendered its approved CON for an additional 24 beds.

2) Economic Feasibility;

Response: Regional One Health Extended Care Hospital has demonstrated successful financial outcomes within its first years of operation. It is anticipated that the addition of these six (6) beds will also realize the same success. Based on the Year 1 budget projections, assuming the project is approved and is initiated within the timeframe as indicated, the long term acute care hospital is anticipated to realize a positive cash flow in the first year. There is minimal capital outlay for the six (6) beds to be added to the LTACH, and this addition provides additional employment opportunities to the healthcare community.

3) Appropriate Quality Standards; and

Response: Regional One Health Extended Care Hospital monitors quality standards through its Quality Assessment and Performance Improvement Program as well as through mandatory Quality reporting to the State of Tennessee and the Centers for Medicare and Medicaid Services (CMS). Benchmarks regarding Core Operational Measures, Key Financial Measures and Clinical Benchmarking are currently maintained by the hospital. The additional six beds would be monitored under the same program to analyze, identify and address areas which are in need of improvement.

4) Orderly Development to adequate and effective health care.

Response: While all four LTACHs in Memphis operated at approximately 85.1% utilization in 2015 (JARs), the Applicant is owned by the only hospital in Memphis that operates a Level One Trauma Center and a Regional Burn Center. Therefore, the Applicant facility is administratively, operationally,
HF-0004 Revised 12/2016 – All forms prior to this time are obsolete. *RDA 1651*

and physically closer to a referring facility with patients who have extended care needs. Further, one of the four LTACHS (Methodist Extended Care) closed on June 20, 2016 and all LTACH patients were discharged. The approval of this application will ensure LTACH patients receive the care they need.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: The Applicant is requesting to be placed on the Consent Calendar. Rationale includes: (1) the Applicant's facility is currently operating at 84.2% based on 24 beds, and at 96.3% based on 21 staffed beds, plus Methodist Hospital has closed its 36 bed LTACH and Select Specialty Hospital recently voluntarily surrendered its approved CON for 24 beds, all of which indicates need for the requested beds; (2) the project is economically feasible and is the most cost-efficient manner in which to provide the needed additional beds; (3) the facility maintains high quality standards and will continue to do so; and (4) the Applicant is administratively, operationally, and physically closer to a referring facility with patients who have extended care needs. Please see Attachment A.3.C.

4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

Shelby County Health Care Corporation
Name

901-545-7676
Phone Number

877 Jefferson Avenue
Street or Route

Shelby
County

Memphis
City

TN
State

38103
Zip Code

B. Type of Ownership of Control (Check One)

- A. Sole Proprietorship _____
B. Partnership _____
C. Limited Partnership _____
D. Corporation (For Profit) _____
E. Corporation (Not-for-Profit) _____

- F. Government (State of TN or Political Subdivision) _____
G. Joint Venture _____
H. Limited Liability Company X
I. Other (Specify) a component unit of Shelby County, TN X (see below)

*Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at <https://tnbear.tn.gov/ECommerce/FilingSearch.aspx>. **Attachment Section A-4A.***

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest. **Regional Med Extended Care Hospital, LLC ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, is an LLC, and is 100% owned by Shelby County Health Care Corporation, a corporation.**

5. Name of Management/Operating Entity (If Applicable)

Murer Consultants

Name

19065 Hickory Creek Drive, Suite 115

Street or Route

Mokena

City

IL

State

Will

County

60448

Zip Code

Website address: <https://murer.com/>

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract. **Attachment Section A-5.**

6A. Legal Interest in the Site of the Institution (Check One)

- | | | | |
|----------------------------|----------|--------------------|-------|
| A. Ownership | _____ | D. Option to Lease | _____ |
| B. Option to Purchase | _____ | E. Other (Specify) | _____ |
| C. Lease of <u>5</u> Years | <u>x</u> | | |

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements **must include** anticipated purchase price. Lease/Option to Lease Agreements **must include** the actual/anticipated term of the agreement **and** actual/anticipated lease expense. The legal interests described herein **must be valid** on the date of the Agency's consideration of the certificate of need application. See Attachments A.6.A.1 and A.6.A.2.

6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site on an 8 1/2" x 11" sheet of white paper, single or double-sided. **DO NOT SUBMIT BLUEPRINTS.** Simple line drawings should be submitted and need not be drawn to scale.

- 1) Plot Plan **must include**:
 - a. Size of site (***in acres***); approximately 18.55Acres (entire hospital complex)
 - b. Location of structure on the site; Applicant located in Turner Tower
 - c. Location of the proposed construction/renovation; on plans; and (n/a)
 - d. Names of streets, roads or highway that cross or border the site. Noted
- 2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 1/2 by 11 sheet of paper or as many as necessary to illustrate the floor plan.
- 3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The facility is located on the 4th Floor of the Turner Tower. The requested beds will be located on the 2nd Floor of the Turner Tower. The site is bounded by Jefferson Avenue, N. Pauline Street, Madison Avenue, and N. Dunlap Avenue. The site is downtown Memphis, close to I-240 and is readily accessible to patients, family members, and other health care providers. Other hospitals are located nearby. This attachment also shows that other providers even own plots of land located within this block.

See Attachments A.6.B.1 and A.6.B.2.

7. **Type of Institution** (Check as appropriate--more than one response may apply)

- | | | | |
|--|----------|--|-------|
| A. Hospital (Specify) <u>LTACH</u> | <u>X</u> | H. Nursing Home | _____ |
| B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty | _____ | I. Outpatient Diagnostic Center | _____ |
| C. ASTC, Single Specialty | _____ | J. Rehabilitation Facility | _____ |
| D. Home Health Agency | _____ | K. Residential Hospice | _____ |
| E. Hospice | _____ | L. Nonresidential Substitution-Based Treatment Center for Opiate Addiction | _____ |
| F. Mental Health Hospital | _____ | M. Other (Specify) _____ | _____ |
| G. Intellectual Disability Institutional Habilitation Facility ICF/IID | _____ | | |

Check appropriate lines(s).

8. **Purpose of Review** (Check appropriate lines(s) – more than one response may apply)

- | | | | |
|--|-------|---|----------|
| A. New Institution | _____ | F. Change in Bed Complement | <u>x</u> |
| B. Modifying an ASTC with limitation still required per CON | _____ | [Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation] | |
| C. Addition of MRI Unit | _____ | G. Satellite Emergency Dept. | _____ |
| D. Pediatric MRI | _____ | H. Change of Location | _____ |
| E. Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify) _____ | _____ | I. Other (Specify) _____ | _____ |

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

x AmeriGroup x United Healthcare Community Plan x BlueCare x TennCare Select

Medicare Provider Number 44-2017

Medicaid Provider Number Q019830

Certification Type Hospital

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare Yes No x N/A Medicaid/TennCare Yes No x N/A

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	<u>Current Licensed</u>	<u>Beds Staffed</u>	<u>Beds Proposed</u>	<u>*Beds Approved</u>	<u>**Beds Exempted</u>	<u>TOTAL Beds at Completion</u>
1) Medical						
2) Surgical						
3) ICU/CCU						
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital	<u>24</u>	<u>21</u>	<u>6</u>			<u>30</u>
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	<u>24</u>	<u>21</u>	<u>6</u>			<u>30</u>

*Beds approved but not yet in service

**Beds exempted under 10% per 3 year provision

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Response:** Attachment Section A-10.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

<u>CON Number(s)</u>	<u>CON Expiration Date</u>	<u>Total Licensed Beds Approved</u>
<u>n/a</u>		

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply: **(Not Applicable)**

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson				Lauderdale			
Bedford				Lawrence			
Benton				Lewis			
Bledsoe				Lincoln			
Blount				Loudon			
Bradley				McMinn			
Campbell				McNairy			
Cannon				Macon			
Carroll				Madison			
Carter				Marion			
Cheatham				Marshall			
Chester				Maury			
Claiborne				Meigs			
Clay				Monroe			
Cocke				Montgomery			
Coffee				Moore			
Crockett				Morgan			
Cumberland				Obion			
Davidson				Overton			
Decatur				Perry			
DeKalb				Pickett			
Dickson				Polk			
Dyer				Putnam			
Fayette				Rhea			
Fentress				Roane			
Franklin				Robertson			
Gibson				Rutherford			
Giles				Scott			
Grainger				Sequatchie			
Greene				Sevier			
Grundy				Shelby			
Hamblen				Smith			
Hamilton				Stewart			
Hancock				Sullivan			
Hardeman				Sumner			
Hardin				Tipton			
Hawkins				Trousdale			
Haywood				Unicoi			
Henderson				Union			
Henry				Van Buren			
Hickman				Warren			
Houston				Washington			
Humphreys				Wayne			
Jackson				Weakley			
Jefferson				White			
Johnson				Williamson			
Knox				Wilson			
Lake							

12. Square Footage and Cost Per Square Footage Chart (Not Applicable – no construction/renovation)

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
New Staff Support							
New Therapy							
New Patient Rooms							
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF							
*Total Cost							
**Cost Per Square Foot							
<p>Cost per Square Foot Is Within Which Range <i>(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)</i></p>					<input type="checkbox"/> Below 1 st Quartile <input type="checkbox"/> Between 1 st and 2 nd Quartile <input type="checkbox"/> Between 2 nd and 3 rd Quartile <input type="checkbox"/> Above 3 rd Quartile	<input type="checkbox"/> Below 1 st Quartile <input type="checkbox"/> Between 1 st and 2 nd Quartile <input type="checkbox"/> Between 2 nd and 3 rd Quartile <input type="checkbox"/> Above 3 rd Quartile	<input type="checkbox"/> Below 1 st Quartile <input type="checkbox"/> Between 1 st and 2 nd Quartile <input type="checkbox"/> Between 2 nd and 3 rd Quartile <input type="checkbox"/> Above 3 rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator (Not Applicable)

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment.

<input type="checkbox"/> Linear Accelerator	Mev _____ Types: _____	<input type="checkbox"/> SRS <input type="checkbox"/> IMRT <input type="checkbox"/> IGRT <input type="checkbox"/> Other _____ <input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life _____ (yrs) <input type="checkbox"/> New <input type="checkbox"/> Refurbished <input type="checkbox"/> If not new, how old? (yrs) _____
<input type="checkbox"/> MRI	Tesla: _____ Magnet: _____ Other _____ <input type="checkbox"/> Breast <input type="checkbox"/> Extremity <input type="checkbox"/> Open <input type="checkbox"/> Short Bore <input type="checkbox"/> _____	<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) _____ <input type="checkbox"/> If not new, how old? (yrs) _____
<input type="checkbox"/> PET	<input type="checkbox"/> PET only <input type="checkbox"/> PET/CT <input type="checkbox"/> PET/MRI <input type="checkbox"/> PET only <input type="checkbox"/> PET/CT <input type="checkbox"/> PET/MRI	<input type="checkbox"/> By Purchase <input type="checkbox"/> By Lease Expected Useful Life (yrs) _____ <input type="checkbox"/> If not new, how old? (yrs) _____

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (Sunday through Saturday)	Hours of Operation (example: 8 am – 3 pm)
Fixed Site (Applicant)	_____	_____
Mobile Locations (Applicant)	_____	_____
(Name of Other Location)	_____	_____
(Name of Other Location)	_____	_____

E. Identify the clinical applications to be provided that apply to the project.

- F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), “no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care.” Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate “Not Applicable (NA).”***

QUESTIONS

SECTION B: NEED

- A. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency’s website at <http://www.tn.gov/hsda/article/hsda-criteria-and-standards>.

Response: See Attachment B.Need.A.

- B. Describe the relationship of this project to the applicant facility’s long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response: The Applicant constantly monitors patient needs and healthcare delivery systems at our facility. While there are no adopted long-range development plans, the fact that sixty (60) approved LTACH beds have been recently closed or surrendered definitely impacts patients we serve. The addition of these six (6) beds is a first step in providing care for the long term acute care hospital patients in need of such services.

- C. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the Border States, if applicable. **Attachment Section B.Need.C.**

Response: Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents	# and % of total patients
County #1	Shelby	98 and 50.0%
	Other Tennessee Counties	26 and 13.3%
Mississippi		37 and 18.9%
Arkansas		23 and 11.7%
	Other States	12 and 6.1%
Total		196 and 100%

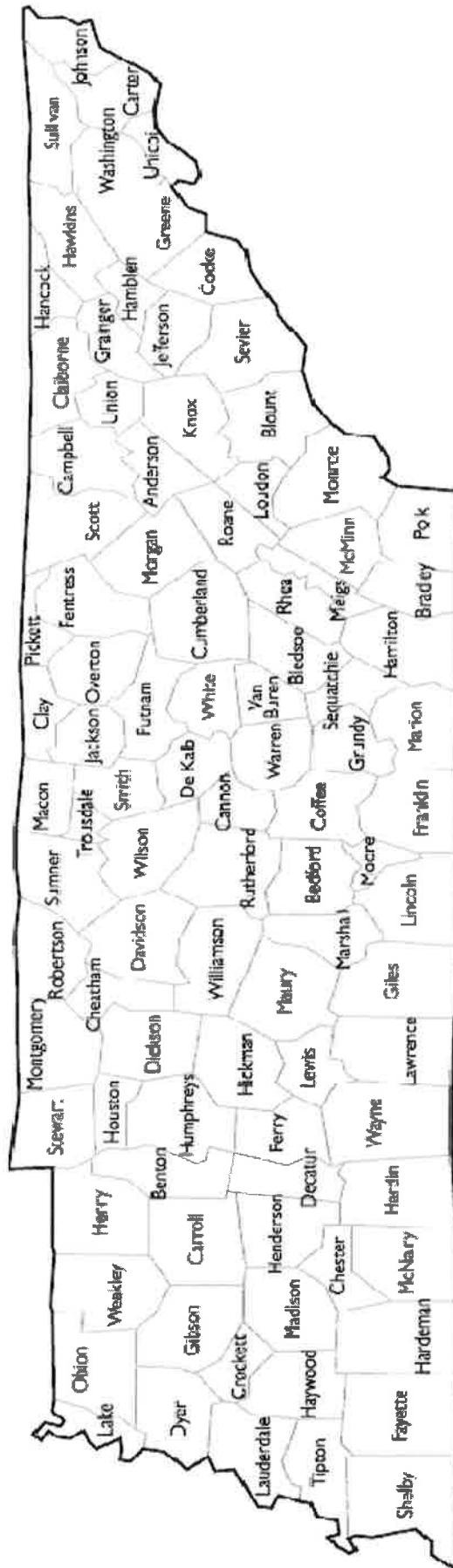
Service Area Counties	Projected Utilization-Co. Residents-6 beds	# and % of total patients
County #1	Shelby	24 and 50.0%
	Other Tennessee Counties	6 and 12.5%
Mississippi		9 and 18.8%
Arkansas		6 and 12.5%
	Other States	3 and 6.3%
Total		48 and 100%

Service Area Counties	Projected Utilization-Co. Residents-30 beds	# and % of total patients
County #1	Shelby	126 and 50.0%
	Other Tennessee Counties	34 and 13.5%
Mississippi		47 and 18.7%
Arkansas		30 and 11.9%
	Other States	15 and 6.0%
Total		252 and 100%

Note: As the service being provided is very specialized, patients originate from a wide geographic area. The facility's existing service area is primarily Shelby County, Tennessee, plus border counties of Mississippi and Arkansas. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant.

ALSO, the Historic Utilization chart above is based on the 2016 JAR, which is not available on the State's website (as of the time of submission of this project).

County Level Map



D. 1). a) Describe the demographics of the population to be served by the proposal.

Response: Shelby County is an urban county with almost one million population covering approximately 763 square miles in the lower left corner of Tennessee. Memphis is the county seat. Approximately 30% of the population has a college degree or higher, and about 20% of the population lives in poverty. Approximately 12.5% of the population is over the age of 65, about 41% is white, and approximately 54% is black or African American. The median value of owner-occupied housing is \$130,000 (from 2011 – 2015), and there are about 347,224 households in Shelby County (from 2011 – 2015). Please see Attachment B.Need.D.1.a for more quick facts about Shelby County.

b) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: <http://www.tn.gov/health/article/statistics-population>

TennCare Enrollment Data: <http://www.tn.gov/tenncare/topic/enrollment-data>

Census Bureau Fact Finder: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

Response: See the following chart:

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Projected Year	*Target Population-% Change	Target Population Projected Year as %	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of	TennCare Enrollees	TennCare Enrollees as % of Total
Shelby County	964804	975626	+1.1	121074	130185	+7.5	13.3	34.6	\$46,224	140398	16.0	249268	25.8
Service Area Total	964804	975626	+1.1	121074	130185	+7.5	13.3	34.6	\$46,224	140398	16.0	249268	25.8
State of TN Total	6887572	7035572	+2.1	1133025	1219696	7.6	17.3	38.4	\$45,219	1117594	15.9	1412063	20.5

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

Long Term Acute Care Hospital services affect all ages. However, for purposes of this question, the “Target Population” will include those aged 65 and over. The chart above reflects that assumption.

- 2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: Shelby County, TN is a medically underserved area, according to Health Resources and Services Administration. The addition of more LTACH beds in the county will add more health care services in the county. Further, while the Applicant will serve all people who present and qualify for nursing services, such services normally target the elderly population. While the elderly population (aged 65+) makes up 17.3% of the population of Tennessee, that same segment of the population represents only 13.3% of the population of Shelby County. Obviously, the population of Shelby County is statistically younger than is the population of the state of Tennessee. Since there are twice as many patients in the existing LTACHs in 2015 than the entire bed need for Shelby County indicated, LTACH patients are obviously originating from other areas. This is in keeping with statements made here and elsewhere about the unique nature of LTACH services, and the wide geographic draw such facilities have. As an example, in 2015 while there were 95 patients from Shelby County at our facility, there were another 38 patients from border counties of Mississippi and 27 patients from border counties of Arkansas. Therefore, the population being served by the Applicant, and these addition requested beds, are in more need of such services than just the population of only Shelby County indicates. The unique nature of the LTACH services we provide indicates special needs for all of the patients we serve, not just those from Shelby County. See Attachment B.Need.D.2 for a list of the MUA tracts and Attachment B.Need.D.3 for a listing of primary care shortage areas in Shelby County.

- E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response: Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) and listed in that order are indicated in the chart below. These numbers are taken off the most recent JARs available (2015).

The Applicant (Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, noted as "Regional Med" in the chart below) lists data for 2017, our most recent data. It is important to note that the Applicant has been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor would result in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity.

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	\$6,987.64	\$5,283.73	\$1,703.91
Methodist	36	31.46	87.4%	\$4,023.54	\$2,661.94	\$1,361.60
Select Specialty	39	36.66	94.0%	\$10,507.78	\$7,388.76	\$3,119.02
Regional MED	24	20.21	84.2%	\$8,499.58	\$6,683.20	\$1,816.38
Total	129	111.22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day
 Adj. = Contractual Adjustments per Patient Day
 Net = Net Operating Revenue per Patient Day

Also, Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

- F. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Based on licensed beds (24), the Applicant has operated at 78.4%, 81.7%, and 84.2% during 2015, 2016, and 2017, respectively. These respective rates would increase to 89.5%, 92.4% and 96.3% based on staffed beds (21). In any regard, the increase in occupancy rate at our hospital indicates a need for more beds.

The Applicant anticipates the occupancy rates for the first two years following completion of the project as follows: Total Facility, 87.4% each year; and the 6 bed addition, only: 82.6% each year. These estimates are based on actual utilization experience of the management company when adding similar numbers of beds to similarly-sized facilities in the past. The only assumption being made is that all of the similar additions that the management company have experienced in the past will replicate on this project. There is nothing known that indicates the facility, the locale, or the population to be served is statistically different from past experience. Further, the recent loss of LTACH beds (detailed below) indicates that the six (6) bed addition will be filled almost immediately.

Finally, Methodist LTACH (36 beds) closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

SECTION B: ECONOMIC FEASIBILITY

A. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- 1) All projects should have a project cost of at least \$15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee).

Response: The filing fee amounts to \$15,000.00.

- 2) The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Response: The Project Costs Chart lists the fair market value of the leased space applicable to this project. The FMV number is much higher than the lease costs for that space.

- 3) The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Response: There is no moveable equipment as suggested by this question.

- 4) Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

Response: Not applicable, as there is neither construction nor renovation involved with this project.

- 5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:
 - a) A general description of the project;
 - b) An estimate of the cost to construct the project;
 - c) A description of the status of the site's suitability for the proposed project; and
 - d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Response: Please see Attachment B.EconomicFeasibility.A.5.

PROJECT COST CHART

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A. Construction and equipment acquired by purchase:		
1.	Architectural and Engineering Fees	
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	40,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Total Construction Costs	
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)	200,000
8.	Moveable Equipment (List all equipment over \$50,000 as separate attachments)	100,000
9.	Other (Specify) _____	
B. Acquisition by gift, donation, or lease:		
1.	Facility (inclusive of building and land) (FMV of leased space)	1,552,500
2.	Building only	
3.	Land only	
4.	Equipment (Specify) _____ (by lease)	307,500
5.	Other (Specify) _____	
C. Financing Costs and Fees:		
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify) _____	
D. Estimated Project Cost (A+B+C)		2,200,000
E.	CON Filing Fee	15,000
F. Total Estimated Project Cost (D+E)		2,215,000
TOTAL		2,215,000

B. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-B.)***

- ☐ 1) Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
- ☐ 2) Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
- ☐ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;
- ☐ 4) Grants – Notification of intent form for grant application or notice of grant award;
- ☐ 5) Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or
- ☒ 6) Other – Identify and document funding from all other sources.

Response: The majority of Project Costs (\$1,860,000) represent the Fair Market Value of the lease, which is part of the annual budget for the Applicant. The remaining amount (\$355,000) will be paid with Cash Reserves of the Applicant. Please see Attachment B.EconomicFeasibility.B.

C. Complete Historical Data Charts on the following two pages—**Do not modify the Charts provided or submit Chart substitutions!**

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that “Management Fees to Affiliates” should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. “Management Fees to Non-Affiliates” should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

HISTORICAL DATA CHART

☐ Total Facility

☐ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

	2015	2016	2017
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days	<u>6,864</u>	<u>7,160</u>	<u>7,378</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>\$45,102,368</u>	<u>\$54,535,080</u>	<u>\$62,709,904</u>
2. Outpatient Services			
3. Emergency Services			
4. Other Operating Revenue (Specify) prior year adjustments			
Gross Operating Revenue	<u>\$45,102,368</u>	<u>\$54,535,080</u>	<u>\$62,709,904</u>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>\$29,817,726</u>	<u>\$40,551,332</u>	<u>\$48,430,137</u>
2. Provision for Charity Care		<u>94,113</u>	<u>279,963</u>
3. Provisions for Bad Debt	<u>686,949</u>	<u>842,985</u>	<u>598,558</u>
Total Deductions	<u>\$30,504,675</u>	<u>\$41,488,430</u>	<u>\$49,308,658</u>
NET OPERATING REVENUE	<u>\$14,597,693</u>	<u>\$13,046,650</u>	<u>\$13,401,246</u>
D. Operating Expenses			
1. Salaries and Wages			
a. Direct Patient Care	<u>3,963,368</u>	<u>4,835,706</u>	<u>5,343,636</u>
b. Non-Patient Care	<u>659,690</u>	<u>481,125</u>	<u>531,661</u>
2. Physician's Salaries and Wages			
3. Supplies	<u>1,690,912</u>	<u>1,889,651</u>	<u>1,966,486</u>
4. Rent			
a. Paid to Affiliates	<u>480,000</u>	<u>480,000</u>	<u>503,500</u>
b. Paid to Non-Affiliates	<u>515,471</u>	<u>370,600</u>	<u>444,568</u>
5. Management Fees:			
a. Paid to Affiliates			
b. Paid to Non-Affiliates	<u>484,234</u>	<u>502,643</u>	<u>504,478</u>
6. Other Operating Expenses	<u>3,468,802</u>	<u>3,844,545</u>	<u>3,472,418</u>
Total Operating Expenses	<u>\$11,262,477</u>	<u>\$12,404,269</u>	<u>\$12,766,746</u>
E. Earnings Before Interest, Taxes and Depreciation	<u>\$3,335,216</u>	<u>\$642,381</u>	<u>\$634,500</u>
F. Non-Operating Expenses			
1. Taxes	\$	\$	\$
2. Depreciation			
3. Interest			
4. Other Non-Operating Expenses			
Total Non-Operating Expenses	\$	\$	\$
NET INCOME (LOSS)	<u>\$3,335,216</u>	<u>\$642,381</u>	<u>\$634,500</u>

Chart Continues Onto Next Page

NET INCOME (LOSS)	<u>\$3,335,216</u>	<u>\$642,381</u>	<u>\$634,500</u>
G. Other Deductions			
1. Annual Principal Debt Repayment	\$	\$	\$
2. Annual Capital Expenditure			
Total Other Deductions	\$	\$	\$
NET BALANCE	<u>\$3,335,216</u>	<u>\$642,381</u>	<u>\$634,500</u>
DEPRECIATION	\$	\$	\$
FREE CASH FLOW (Net Balance + Depreciation)	<u>\$3,335,216</u>	<u>\$642,381</u>	<u>\$634,500</u>

☐ **Total Facility**

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	2015	2016	2017
1. Professional Services Contract	<u>\$528,032</u>	<u>\$1,387,215</u>	<u>\$1,332,488</u>
2. Contract Labor	<u>118,455</u>	<u>141,661</u>	<u>29,981</u>
3. Imaging Interpretation Fees	<u>66,270</u>	<u>70,107</u>	<u>103,065</u>
4. Benefits	<u>1,086,623</u>	<u>1,066,808</u>	<u>1,019,357</u>
5. General & Administrative	<u>934,746</u>	<u>635,631</u>	<u>429,570</u>
6. Other	<u>734,676</u>	<u>543,123</u>	<u>567,957</u>
Total Other Expenses	<u>\$3,468,802</u>	<u>\$3,844,545</u>	<u>\$3,472,418</u>

D. Complete Projected Data Charts on the following two pages – **Do not modify the Charts provided or submit Chart substitutions!**

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the **Proposal Only** (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that “Management Fees to Affiliates” should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. “Management Fees to Non-Affiliates” should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

PROJECTED DATA CHART

☐ Total Facility
☐ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

	Year 1 (2018)	Year 2 (2019)
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days.	<u>9,565</u>	<u>9,565</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$78,433,340</u>	<u>\$78,433,340</u>
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify) vending, food, rebates		
Gross Operating Revenue	<u>\$78,433,340</u>	<u>\$78,433,340</u>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$60,584,445</u>	<u>\$60,584,445</u>
2. Provision for Charity Care	<u>389,786</u>	<u>389,786</u>
3. Provisions for Bad Debt	<u>235,390</u>	<u>235,390</u>
Total Deductions	<u>\$61,209,621</u>	<u>\$61,209,621</u>
NET OPERATING REVENUE	<u>\$17,223,719</u>	<u>\$17,223,719</u>
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	<u>6,540,253</u>	<u>6,671,058</u>
b. Non-Patient Care	<u>650,717</u>	<u>663,731</u>
2. Physician's Salaries and Wages		
3. Supplies	<u>2,889,423</u>	<u>2,947,211</u>
4. Rent		
a. Paid to Affiliates	<u>542,500</u>	<u>553,350</u>
b. Paid to Non-Affiliates	<u>440,000</u>	<u>448,800</u>
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	<u>385,296</u>	<u>393,002</u>
6. Other Operating Expenses	<u>3,666,273</u>	<u>3,739,598</u>
Total Operating Expenses	<u>\$15,114,462</u>	<u>\$15,416,750</u>
E. Earnings Before Interest, Taxes and Depreciation	<u>\$2,109,257</u>	<u>\$1,806,969</u>
F. Non-Operating Expenses		
1. Taxes	<u>\$</u>	<u>\$</u>
2. Depreciation		
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	<u>\$</u>	<u>\$</u>
NET INCOME (LOSS)	<u>\$2,109,257</u>	<u>\$1,806,969</u>

Chart Continues Onto Next Page

NET INCOME (LOSS)	<u>\$2,109,257</u>	<u>\$1,806,969</u>
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	\$	\$
2. Annual Capital Expenditure		
Total Other Deductions	\$	\$
NET BALANCE	<u>\$2,109,257</u>	<u>\$1,806,969</u>
DEPRECIATION	\$	\$
FREE CASH FLOW (Net Balance + Depreciation)	<u>\$2,109,257</u>	<u>\$1,806,969</u>

☐ **Total Facility**
☐ **Project Only**

PROJECTED DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	<u>Year2018</u>	<u>Year 2019</u>
1. Professional Services Contract	<u>\$1,453,479</u>	<u>\$1,464,189</u>
2. Contract Labor	<u>25,000</u>	<u>25,500</u>
3. Imaging Interpretation Fees	<u>95,000</u>	<u>96,900</u>
4. Benefits	<u>1,152,235</u>	<u>1,175,280</u>
5. General and Administrative	<u>500,000</u>	<u>510,000</u>
6. Other	<u>440,559</u>	<u>467,729</u>
Total Other Expenses	<u>\$3,666,273</u>	<u>\$3,739,598</u>

PROJECTED DATA CHART

☐ Total Facility
☐ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

	<u>Year 1</u> <u>(2018)</u>	<u>Year 2</u> <u>(2019)</u>
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days.	<u>1,810</u>	<u>1,810</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$14,842,000</u>	<u>\$14,842,000</u>
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify)Vending, Food, Rebates		
Gross Operating Revenue	<u>\$14,842,000</u>	<u>\$14,842,000</u>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$11,463,994</u>	<u>\$11,463,994</u>
2. Provision for Charity Care	<u>37,838</u>	<u>37,838</u>
3. Provisions for Bad Debt	<u>80,898</u>	<u>80,898</u>
Total Deductions	<u>\$11,582,730</u>	<u>\$11,582,730</u>
NET OPERATING REVENUE	<u>\$3,259,270</u>	<u>\$3,259,270</u>
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	<u>679,205</u>	<u>692,789</u>
b. Non-Patient Care	<u>67,577</u>	<u>68,929</u>
2. Physician's Salaries and Wages		
3. Supplies	<u>710,138</u>	<u>724,341</u>
4. Rent		
a. Paid to Affiliates	<u>125,000</u>	<u>127,500</u>
b. Paid to Non-Affiliates		
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating Expenses	<u>116,300</u>	<u>118,626</u>
Total Operating Expenses	<u>\$1,698,220</u>	<u>\$1,732,185</u>
E. Earnings Before Interest, Taxes and Depreciation	<u>\$1,561,050</u>	<u>\$1,527,085</u>
F. Non-Operating Expenses		
1. Taxes	<u>\$</u>	<u>\$</u>
2. Depreciation		
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	<u>\$</u>	<u>\$</u>
NET INCOME (LOSS)	<u>\$1,561,050</u>	<u>\$1,527,085</u>

Chart Continues Onto Next Page

NET INCOME (LOSS)	<u>\$1,561,050</u>	<u>\$1,527,085</u>
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	\$	\$
2. Annual Capital Expenditure		
Total Other Deductions	\$	\$
NET BALANCE	<u>\$1,561,050</u>	<u>\$1,527,085</u>
DEPRECIATION	\$	\$
FREE CASH FLOW (Net Balance + Depreciation)	<u>\$1,561,050</u>	<u>\$1,527,085</u>

- ☐ Total Facility
☐ **Project Only**

PROJECTED DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	<u>Year 2018</u>	<u>Year 2019</u>
1. Professional Services Contract	\$	\$
2. Contract Labor		
3. Imaging Interpretation Fees		
4. Benefits	<u>116,300</u>	<u>118,626</u>
5. General and Administrative		
6. Other		
Total Other Expenses	<u>\$116,000</u>	<u>\$118,626</u>

- E. 1) Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year (2016)	Current Year (2017)	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge (<i>Gross Operating Revenue/Utilization Data</i>)	7,616.63	8,499.58	8,200.04	8,200.04	-3.5
Deduction from Revenue (<i>Total Deductions/Utilization Data</i>)	5,794.47	6,683.20	6,399.33	6,399.33	-4.2
Average Net Charge (<i>Net Operating Revenue/Utilization Data</i>)	1,822.16	1,816.38	1,800.71	1,800.71	-0.9

- 2) Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The proposed charges for the total project are reflected in the table above: Year 1, \$8,200.04 in gross operating revenue per patient day, \$6,399.33 in contractual adjustments per patient day; and \$1,800.71 in net operating revenue per patient day. The implementation of this project, coupled with normal increases in costs, will decrease the average net charge per patient day by approximately 0.9% in two years. This decrease is to be expected due to cost efficiencies in operating a larger facility.

- 3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Our existing (and projected) service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) are indicated in the chart below. These numbers are taken off the most recent JARs available (2015). It is important to note that Methodist Extended Care is now closed.

The Applicant (Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, noted as “Regional Med” in the chart below) lists data for 2017, our most recent data. It is important to note that the Applicant has been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor would result in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity.

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	\$6,987.64	\$5,283.73	\$1,703.91
Methodist	36	31.46	87.4%	\$4,023.54	\$2,661.94	\$1,361.60
Select Specialty	39	36.66	94.0%	\$10,507.78	\$7,388.76	\$3,119.02
Regional MED	24	20.21	84.2%	\$8,499.58	\$6,683.20	\$1,816.38
Total	129	111.22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day
Adj. = Contractual Adjustments per Patient Day
Net = Net Operating Revenue per Patient Day

Also, Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

- F. 1) Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-F1**. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: Based on the Year 1 budget projections, and assuming the project is approved and is initiated within the timeframe as indicated, the long term acute care hospital is anticipated to realize a positive cash flow in the first year following completion of the addition. We believe the additional beds will fill up almost immediately.

Financials are included as Attachment B.EconomicFeasibility.F.1.

- 2) Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Response: Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	22.8%	4.9%	4.7%	12.2%	10.5%

- 3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: $[\text{Long-term debt}/(\text{Long-term debt} + \text{Total Equity (Net assets)})] \times 100$.

Response: For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

$$\frac{\text{Long Term Debt}}{(\text{Long Term Debt} + \text{Total Equity}) \times 100} = \frac{0}{(0 + 11846000) \times 100} = 0$$

For Owner:

$$\frac{\text{Long Term Debt}}{(\text{Long Term Debt} + \text{Total Equity}) \times 100} = \frac{41,829,738}{(41,829,738 + 242,947,894) \times 100} = 0.0015 \text{ or } 0.15\%$$

- G. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: Historical:

Payor Source	Projected Gross Operating Revenue (\$)	As a % of Total
Medicare/Medicare Managed Care	41,937,308	66.9
TennCare/Medicaid	6,310,878	10.1
Commercial/Other Managed Care	12,637,108	20.2
Self-Pay	119,605	0.2
Charity Care		
Other (Specify) Worker's Compensation	1,705,005	2.7
Total	62,709,904	100.0

Project Only Projected Yr1:

Payor Source	Projected Gross Operating Revenue (\$)	As a % of Total
Medicare/Medicare Managed Care	9,926,847	66.9
TennCare/Medicaid	1,493,828	10.1
Commercial/Other Managed Care	2,991,290	20.2
Self-Pay	28,311	0.2
Charity Care		
Other (Specify) Worker's Compensation	401,724	2.7
Total	14,842,000	100.0

Total Facility Projected Yr 1:

Payor Source	Projected Gross Operating Revenue (\$)	As a % of Total
Medicare/Medicare Managed Care	52,458,953	66.9
TennCare/Medicaid	7,894,213	10.1
Commercial/Other Managed Care	15,807,630	20.2
Self-Pay	149,613	0.2
Charity Care		
Other (Specify) Worker's Compensation	2,122,931	2.7
Total	78,433,340	100.0

- H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: Please see chart below:

Position Classification	Existing FTE 2017	Projected FTE (Year 1)	Avg Wage \$ (contractual rate)	Avg Wage \$ Area/State
RN	38.0	53.3	32.71	31.75
CNA	9.9	10.1	13.23	12.95
Patient Care Extern	0.4	0.5	18.69	31.75
Dir. Respiratory Care	1.0	1.0	42.52	31.75
Liaison Nurse	2.0	2.0	34.88	31.75
Lead Respiratory Therapist	1.2	1.0	29.42	31.75
Occupational Therapist	0.9	0.8	47.67	31.75
Physical Therapist	0.9	0.9	48.18	31.75
Speech Pathologist	0.9	1.0	47.44	31.75
Patient Care Coordinator	4.0	3.5	30.35	31.75
Resp Ther/RRT	9.9	10.2	24.19	31.75
Medical Assistant	2.0	2.0	13.91	12.95
Physical Ther Asst	1.1	1.1	29.88	31.75
Resp Ther Tech/Cert	1.0	1.0	23.74	31.75
Patient Serv Clerk	5.6	5.5	14.57	12.95
a. Total Direct Care	78.7	93.8		
Nursing Clin Supv	0.6	1.0	45.67	43.95
Chief Nursing Officer	1.0	1.0	58.85	43.95
Dir HIM	1.0	1.0	37.02	43.95
Case Mgr/RN	1.0	1.1	33.97	43.95
HIM Coding Spec	0.4	0.1	22.00	12.95
Admitting Coordinator	1.0	1.0	19.85	12.95
Pre-Certification Nurse	0.9	1.9	33.65	12.95
CMS Data Coordinator	0.9	1.0	19.31	12.95
Admin Secretary	0.2	0.0	16.50	12.95
b. Total Non-Direct	6.9	8.1		
Contracted Therapy				
Contracted Med Dir/Diet.				
c. Total Contractual	0.0	0.0		
Total Staff (a + b + c)	85.6	101.9		

I. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

- 1) Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

Response: First, doing nothing is always an alternative, but was discarded since our high utilization and other factors indicate a need for more LTACH beds. Second, the construction of a new facility was discarded as such would be cost-prohibitive. It was felt that utilizing existing space on campus would be the most cost-efficient manner in which to provide the additional beds, plus the fastest manner in which to do so. The LTACH Moratorium, which expires in October, 2017, prevented us from adding beds in the past.

- 2) Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response: First, doing nothing is always an alternative, but was discarded since our high utilization and other factors indicate a need for more LTACH beds. Second, the construction of a new facility was discarded as such would be cost-prohibitive. It was felt that utilizing existing space on campus would be the most cost-efficient manner in which to provide the additional beds, plus the fastest manner in which to do so. The LTACH Moratorium, which expires in October, 2017, prevented us from adding beds in the past.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

- A. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

Response: We have a transfer agreement with Regional One Health. Our medical director and physician group agreement is with Sleep and Pulmonary Specialist, PLLC.

- B. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

1) Positive Effects

Response: The provision of healthcare services to patients in need normally has a positive impact on those patients, and this project is no exception. Once these beds are approved and licensed, the Applicant will be in a better position to provide needed services to patients requiring LTACH care. Further, since sixty (60) LTACH beds have been voluntarily surrendered within the past year, the addition of these requested beds will have little impact on existing providers in the area.

2) Negative Effects

Response: The Applicant is unaware of any negative impact that this project might have on the health care system.

- C. 1) Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response: The Applicant hires mostly experienced staff from the local healthcare market, through formal recruitment plans and efforts as well as informal. We have a formal nurse extern program through which we have made direct hires upon successful completion. We believe that we have the clinical leadership already on staff, and adequate professional staff is available locally.

- 2) Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response: The Applicant understands these standards.

- 3) Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: The Applicant, through its Owner, has an agreement with UT Medical School to train physicians and those physicians rotate through our LTACH (Please see Attachment B.OrderlyDevelopment.C.3). In addition, we have agreements with both the University of Memphis, College of Nursing, and with Union College for the training of nursing students, and an agreement with Concord Career College for the training of Respiratory Therapy students.

- D. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response: Please see below:

Licensure: Tennessee Department of Health

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.): Hospital, certified in Medicare, Medicaid/TennCare patients served through various MCO contracts.

Accreditation (i.e., Joint Commission, CARF, etc.): Not Applicable

- 1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Response: The Applicant is an existing hospital, licensed by the Tennessee Department of Health (#36), and a copy of the license is provided as Attachment B.OrderlyDevelopment.D.1.

- 2) For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: The Applicant's latest survey and POC are provided as Attachment B.OrderlyDevelopment.D.2.

- 3) Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

- a) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response: Not applicable.

E. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

- a) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response: No.

- b) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Response: No.

- c) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response: No.

2) Been subjected to any of the following:

- a) Final Order or Judgment in a state licensure action;

Response: No.

- b) Criminal fines in cases involving a Federal or State health care offense;

Response: No.

- c) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: No.

- d) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: No.

- e) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: No.

- f) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: No.

- g) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: No.

- h) Is presently subject to a corporate integrity agreement.

Response: No.

F. Outstanding Projects:

- 1) Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

<u>Outstanding Projects</u>					
<u>CON Number</u>	<u>Project Name</u>	<u>Date Approved</u>	<u>*Annual Progress Report(s)</u>		<u>Expiration Date</u>
			<u>Due Date</u>	<u>Date Filed</u>	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

- 2) Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: There are no outstanding projects.

G. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

- 1) Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____
- 2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission? _____
- 3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____

Response: Not Applicable.

SECTION B: QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The Applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at <http://www.tn.gov/health/topic/health-planning>). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

A. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Response: The Applicant provides inpatient long term acute care hospital (LTACH) services to an area that has recently lost many LTACH beds. An existing LTACH (Methodist Extended Care) closed and turned in its license to operate thirty-six (36) LTACH beds on June 20, 2016, and another existing LTACH (Select Specialty Hospital) turned in its approved CON to add twenty-four (24) beds on July 10, 2017. This means sixty (60) existing and/or approved LTACH beds will not be available to serve patients who need those services. This application, to add six (6) LTACH beds, is a small step in alleviating that problem, and will improve the health of the people of Tennessee who require such services.

The Applicant's goal of continuing to provide these appropriate and needed services is consistent with the State Health Plan, and this project will improve the health of Tennesseans.

B. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response: The Applicant will continue to provide a service currently needed by all citizens in the service area.

C. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response: The development of services by the Applicant has always been the result of attempts to meet the needs of the Tennesseans it serves. There is an unmet need for LTACH care in the service area. There currently exist only ninety-three (93) LTACH beds in the service area, but one hundred fifty-three LTACH beds have been approved for the same service area, a shortage of sixty (60) beds. Therefore, the approval of this application will enhance the development of more LTACH services for residents in the proposed service area.

D. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response: Tennessee is fortunate to have an excellent licensing division of the Department of Health. The Board of Licensing Health Care Facilities provides standards for and monitoring of licensed health care providers. This Applicant will continue to be licensed by the Department of Health and will be certified by Medicare, and Medicaid (TennCare).

E. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response: The Applicant is committed to providing its staff both safe working conditions and continuing education.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Proof of Publication is attached.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Response: Not Applicable.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

Response: The Project Completion Forecast Chart is completed.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1 below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

<u>Phase</u>	<u>Days Required</u>	<u>Anticipated Date [Month/Year]</u>
1. Initial HSDA decision date		10/2017
2. Architectural and engineering contract signed		
3. Construction documents approved by the Tennessee Department of Health		
4. Construction contract signed		
5. Building permit secured		
6. Site preparation completed		
7. Building construction commenced		
8. Construction 40% complete		
9. Construction 80% complete		
10. Construction 100% complete (approved for occupancy)		
11. *Issuance of License		01/2018
12. *Issuance of Service		02/2018
13. Final Architectural Certification of Payment		
14. Final Project Report Form submitted (Form HR0055)		

*For projects that **DO NOT** involve construction or renovation, complete Items 11 & 12 only.

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

AUG 14 17 PM 2:29

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

E. Graham Baker, Jr., being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of his knowledge, information and belief.



SIGNATURE/TITLE

Sworn to and subscribed before me this 14TH day of August, 2017
(Month) (Year)

a Notary Public in and for the County/State of Davidson/Tennessee.



NOTARY PUBLIC

My commission expires March 3, 2020.
Month/Day (Year)



ANDERSON & BAKER

An Association of Attorneys

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ROBERT A. ANDERSON

Direct: 615-383-3332

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E. GRAHAM BAKER, JR.

Direct: 615-370-3380

Facsimile: 615-221-0080

August 14, 2017

Melanie Hill, Executive Director
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Regional MED Extended Care Hospital, LLC,
d/b/a Regional One Health Extended Care Hospital
Request to be placed on Consent Calendar

Dear Ms. Hill:

I represent the referenced hospital, am filing a Certificate of Need application today for the addition of six (6) beds to the facility, and respectfully request this application be placed on the Consent Calendar. The rationale for this request includes: (1) the Applicant's facility is currently operating at 84.2% based on 24 beds, and at 96.3% based on 21 staffed beds, plus Methodist Hospital has closed its 36 bed LTACH and Select Specialty Hospital recently voluntarily surrendered its approved CON for 24 beds, all of which indicates need for the requested beds; (2) the project is economically feasible and is the most cost-efficient manner in which to provide the needed additional beds; (3) the facility maintains high quality standards and will continue to do so; and (4) the Applicant is administratively, operationally, and physically closer to a referring facility with patients who have extended care needs.

Please contact me if you have need for further information in this regard.

Respectfully,



E. Graham Baker, Jr.



March 3, 2017

Kathy Zeigler, RN
Department of Health
West Tennessee Health Care Facilities
2975 C Highway 45 Bypass
Jackson, TN 38305-3608

VIA: Federal Express

Re: Regional One Health Extended Care Hospital Life Safety Plan of Correction Response

Dear Ms. Kathy Zeigler,

Please accept this letter and enclosed documentation on behalf of Regional One Health Extended Care Hospital in response to correspondence received from your office dated February 23, 2017. The attached Plan of Correction describes how Regional One Health Extended Care Hospital will correct the cited deficiencies and the time frame for completion of the work; specifically the fire stop systems which will be used to repair each penetration.

We believe that the enclosed provides the requested information, but ask that you contact me at mkelly@regionalonehealth.org or (901) 515-3030 if you have any questions, or if anything further is needed. Thank you in advance for your time and attention to this matter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mark Kelly', written over a horizontal line.

Mark Kelly
CEO/Administrator

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531186-LT	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2017
---	---	--	---

NAME OF PROVIDER OR SUPPLIER REGIONAL ONE HEALTH EXTENDED CARE HOSPITA	STREET ADDRESS, CITY, STATE, ZIP CODE 880 MADISON AVENUE, 4TH FLOOR MEMPHIS, TN 38103
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	<p>1200-08-01-.08 (1) Building Standards</p> <p>(1) A hospital shall construct, arrange, and maintain the condition of the physical plant and the overall hospital environment in such a manner that the safety and well-being of the patients are assured.</p> <p>This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 101, 8.2.2.2 (2012 Ed.) Fire compartments shall be formed by fire barriers complying with 8.3. NFPA 101, 8.3.1.3 (2012 Ed.) Walls used as fire barriers shall comply with Chapter 7 of NFPA 221, Standard for High Challenge Fire Walls, Fire Walls, and Fire Barrier Walls.</p> <p>NFPA 221, 7.1 (2012 Ed.) Fire barrier walls shall meet the requirements of this chapter and Chapter 4 except as modified by this chapter.</p> <p>NFPA 221, 4.9.2 (2012 Ed.) Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. [5000:8.8.2]</p> <p>NFPA 221, 4.9.3 (2012 Ed.) Where the penetrating item uses a sleeve to</p>	H 871	<p>For all findings documented in this report, the Regional One Health Director, Engineering Services, is responsible for the corrective action and for overall/ongoing compliance. The Director is 3M Certified in Fire Protection and completed the 3M <i>Through Penetrations Program</i>. The Director and team will be utilizing Hilti systems and products.</p> <p>The experienced team from American Program Management, LLC. will continue to monitor projects. This firm specializes in health care facility design.</p> <p>Any contractors with a need to work above the ceiling will be required to contact Facility Engineering and complete an above ceiling permit prior to starting any work that affects fire barriers. A follow-up inspection will be conducted when work is completed to ensure 100% compliance with this requirement.</p> <p>The Administrator of Regional One Health Extended Care Hospital shall monitor the progress of Regional One Health's team to ensure completion. Ongoing review of environment services provided by Regional One Health Extended Care Optional, shall be monitored to ensure timely handling by the Regional One Health Extended Care Hospital quality program.</p>	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

5450

NHRN21

CEO

3-MARCH 2017

If continuation sheet 1 of 5

Division of Health Care Facilities
STATE FORM

Division of Health Care Facilities
STATE FORM

If continuation sheet 4 of 5

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP531186-LT	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	(X3) DATE SURVEY COMPLETED 01/11/2017
NAME OF PROVIDER OR SUPPLIER REGIONAL ONE HEALTH EXTENDED CARE HOSPITA		STREET ADDRESS, CITY, STATE, ZIP CODE 890 MADISON AVENUE, 4TH FLOOR MEMPHIS, TN 38103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	Continued From page 4 7. Observation on 1/11/17 at 12:50 PM, revealed the following penetrations above the 45 minute fire doors to the storage area: a. drywall tape seams and ends were exposed. b. 2 - 1 inch metal conduits were not sealed per an approved method. c. the 2 inch black steel sprinkler line had mixed fire stop. d. a 1 inch metal sleeve was not sealed at the wall. National Fire Protection Association (NFPA) 101, 8.2.2.2 (2012 Ed.) Fire compartments shall be formed by fire barriers complying with 8.3.1.3 (2012 Ed.) NFPA 221, 7.1 (2012 Ed.) NFPA 221, 4.9.2 (2012 Ed.) NFPA 221, 4.9.3 (2012 Ed.) The project manager was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit interview on 1/11/17.	H 871	6c. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 7a. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 7b. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 7c. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 7d. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054.	2/25/2017 2/25/2017

ATTACHMENT "A"

CAULK

SEE REFLECTED
CEILING PLAN

CAULK

FIRE TAPE JOINTS
ABOVE CEILING EA.
SIDE

SEE REFLECTED
CEILING PLAN

5/8" TYPE X GYP. BD.

BATT INSULATION

NOTE: CAULK ALL
PENETRATIONS AND JOINTS
TO LIMIT THE PASSAGE OF
FREE SMOKE

AS PER SCHED.

E

1 HR RATEI
DOUBLE 3 5/
TYPE X GYI

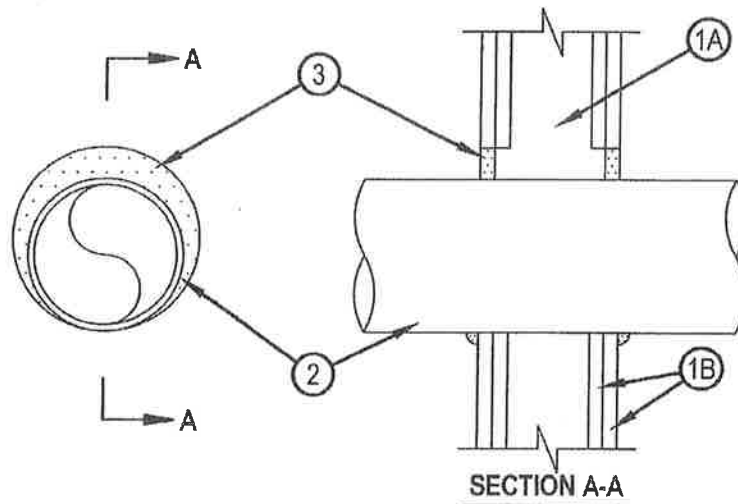


Classified by
Underwriters Laboratories, Inc.
to UL 1479 and CAN/ULC-S115

System No. W-L-1054

WL 1054

ANSI/UL1479 (ASTM E814)	CAN/ULC S115
F Ratings — 1 and 2 Hr (See Items 1 and 3)	F Ratings — 1 and 2 Hr (See Items 1 and 3)
T Rating — 0 Hr	FT Rating — 0 Hr
L Rating at Ambient — Less Than 1 CFM/sq ft	FH Ratings — 1 and 2 Hr (See Items 1 and 3)
L Rating at 400 F — Less Than 1 CFM/sq ft	FTH Rating — 0 Hr
	L Rating at Ambient — Less Than 1 CFM/sq ft
	L Rating at 400 F — Less Than 1 CFM/sq ft



1. Wall Assembly — The 1 or 2 hr fire-rated gypsum wallboard/stud wall assembly shall be constructed of the materials and in the manner specified in the individual U300 or U400 Series Wall and Partition Designs in the UL Fire Resistance Directory and shall include the following construction features:

A. Studs — Wall framing may consist of either wood studs or steel channel studs. Wood studs to consist of nom 2 by 4 in. (51 by 102 mm) lumber spaced 16 in. (406 mm) OC. Steel studs to be min 2-1/2 in. (64 mm) wide and spaced max 24 in. (610 mm) OC. When steel studs are used and the diam of opening exceeds the width of stud cavity, the opening shall be framed on all sides using lengths of steel stud installed between the vertical studs and screw-attached to the steel studs at each end. The framed opening in the wall shall be 4 to 6 in. (102 to 152 mm) wider and 4 to 6 in. (102 to 152 mm) higher than the diam of the penetrating item such that, when the penetrating item is installed in the opening, a 2 to 3 in. (51 to 76 mm) clearance is present between the penetrating item and the framing on all four sides.

B. Gypsum Board* — 5/8 in. (16 mm) thick, 4 ft (122 cm) wide with square or tapered edges. The gypsum board type, thickness, number of layers, fastener type and sheet orientation shall be as specified in the individual U300 or U400 Series Design in the UL Fire Resistance Directory. Max diam of opening is 32-1/4 in. (819 mm) for steel stud walls. Max diam of opening is 14-1/2 in. (368 mm) for wood stud walls. The F and FH Ratings of the firestop system are equal to the fire rating of the wall assembly.



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October 14, 2015

System No. W-L-1054

WL 1054

2. Through-Penetrants — One metallic pipe, conduit or tubing to be installed either concentrically or eccentrically within the firestop system. The annular space shall be min 0 in. to max 2-1/4 in. (57 mm). Pipe may be installed with continuous point contact. Pipe, conduit or tubing to be rigidly supported on both sides of wall assembly. The following types and sizes of metallic pipes, conduits or tubing may be used:
- A. Steel Pipe — Nom 30 in. (762 mm) diam (or smaller) Schedule 10 (or heavier) steel pipe.
 - B. Iron Pipe — Nom 30 in. (762 mm) diam (or smaller) cast or ductile iron pipe.
 - C. Conduit — Nom 4 in. (102 mm) diam (or smaller) steel electrical metallic tubing or 6 in. (152 mm) . diam steel conduit.
 - D. Copper Tubing — Nom 6 in. (152 mm) diam (or smaller) Type L (or heavier) copper tubing.
 - E. Copper Pipe — Nom 6 in. (152 mm) diam (or smaller) regular (or heavier) copper pipe.
3. Fill, Void or Cavity Material* — Sealant — Min 5/8 in. (16 mm) thickness of fill material applied within the annulus, flush with both surfaces of wall. At the point or continuous contact locations between pipe and wall, a min 1/2 in. (13 mm) diam bead of fill material shall be applied at the pipe wall interface on both surfaces of wall.
- HILTI CONSTRUCTION CHEMICALS, DIV OF HILTI INC — FS-One Sealant or FS-ONE MAX Intumescent Sealant

* Indicates such products shall bear the UL or cUL Certification Mark for jurisdictions employing the UL or cUL Certification (such as Canada), respectively.



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Page: 2 of 2

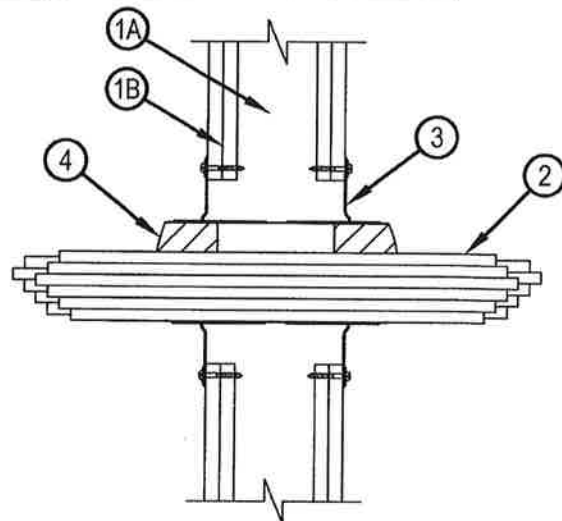
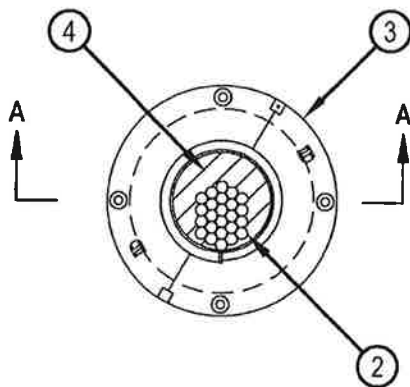


Classified by
Underwriters Laboratories, Inc.
to UL 1479 and CAN/ULC-S115

System No. W-L-3393

WL 3393

ANSI/UL1479 (ASTM E814)	CAN/ULC S115
F Ratings - 1 and 2 Hr (See Item 1)	F Ratings - 1 and 2 Hr (See Item 1)
T Ratings - 0, 3/4 and 1 Hr (See Items 2 and 3)	FT Ratings - 0, 3/4 and 1 Hr (See Items 2 and 3)
L Rating At Ambient - See Item 4	FH Ratings - 1 and 2 Hr (See Item 1)
L Rating At 400F - See Item 4	FTH Ratings - 0, 3/4 and 1 Hr (See Items 2 and 3)
	L Rating At Ambient - See Item 4
	L Rating At 400F - See Item 4



SECTION A-A

1. Wall Assembly — The 1 or 2 hr fire rated gypsum board/stud wall assembly shall be constructed of the materials and in the manner described within the individual U300, U400, V400 or W400 Series Wall and Partition Designs in the UL Fire Resistance Directory and shall incorporate the following construction features:

A. Studs — Wall framing shall consist of either wood studs or steel channel studs. Wood studs to consist of nom 2 by 4 in. (51 by 102 mm) lumber spaced max 16 in. (406 mm) OC. Steel studs to be min 3-1/2 in. (89 mm) wide and spaced max 24 in. (610 mm) OC.

B. Gypsum Board* — Nom 5/8 in. (16 mm) thick gypsum board as specified in the individual Wall and Partition Design. Opening in gypsum board to be max 8 in. (203 mm) diam for 4" device and max 6 in. (152 mm) diam for 2" device.

The hourly F and FH Ratings of the firestop system are dependent upon the hourly rating of the wall in which it is installed.



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January 25, 2013

2. Cables — Within the loading area for each firestop device, the aggregate cross-sectional area of cables to be min 0 to max 60 percent fill. Cables to be tightly bundled within the device and rigidly supported on both sides of wall assembly. Any combination of the following types of cables may be used:

- A. Max 100 pair No. 24 AWG (or smaller) copper conductor telecommunication cable with polyvinyl chloride (PVC) jacketing and insulation.
- B. Max 7/C No. 12 AWG copper conductor control cable with PVC or XLPE jacket and insulation.
- C. Max 4/0 AWG Type RHH ground cable.
- D. Max 4 pr No. 22 AWG Cat 5 or Cat 6 computer cables.
- E. Max RG 6/U coaxial cable with fluorinated ethylene insulation and jacketing.
- F. Fiber optic cable with polyvinyl chloride (PVC) or polyethylene (PE) jacket and insulation having a max diam of 1/2 in. (13 mm).
- G. Max 3/C No 12 AWG MC Cable.

For opening with cables, when the hourly rating of the wall assembly is 1 hr, the T, FT and FTH Ratings are 0 hr. For opening with cables, when the hourly rating of the wall assembly is 2 hr, the T, FT and FTH Ratings are 1 hr except that when Item 2C is used, the T, FT and FTH Ratings are 3/4 hr.

3. Firestop Device* — Firestop device consists of a corrugated steel tube with a flange at each end that is spun clockwise onto device threads, butting tightly to both sides of wall. Each flange is secured to face of wall with min four No. 10 by 1-1/2 in. (38 mm) steel laminating screws through prepunched holes in flange. Device is designed to allow installation before or after the cable penetrants are in place. Device slid into wall such that ends project an equal distance from the approximate centerline of the wall assembly. The annular space between the device and the periphery of the opening shall be min 0 in. (point contact) to max 2 in. (51 mm). For blank openings (no cables) in 2 hr rated walls, the T, FT and FTH Ratings for the firestop system are 1 hr. For blank openings (no cables) in 1 hr rated walls, the T, FT and FTH Ratings are 0 hr.

HILTI CONSTRUCTION CHEMICALS, DIV OF HILTI INC — CFS-SL RK 2" and 4" Firestop Sleeve

4. Fill, Void or Cavity Material* - Plug — Nom 2 or 4 in. (51 or 102 mm) plug sized for the firestop device (Item 3) friction fit within the sleeve flush with the end of the sleeve on both sides of the wall assembly. Plug cut to fit around the cable bundle and installed tightly within the sleeve.

HILTI CONSTRUCTION CHEMICALS, DIV OF HILTI INC — CFS-PL Firestop Plug

The following L Ratings are covered. Cable bundle shall be centered within the device.

	CFM (per device)		CFM/Sq Ft Opening	
	Ambient	400°F	Ambient	400°F
Blank Opening (no cables)	1.3	1.1	3.8	3.0
Max 33% aggregate cable fill	2.8	1.2	8.1	3.3



Hilti Firestop Systems

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January 25, 2013

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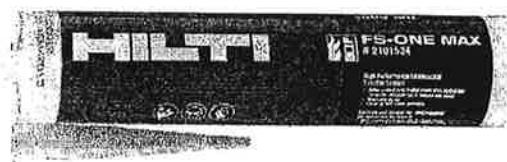
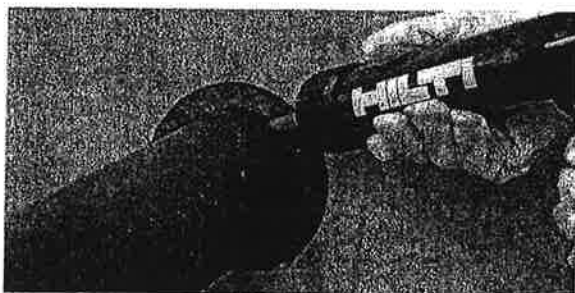
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FIRESTOP SEALANT FS-ONE MAX

Take coverage and performance to the max.

Even the best product on the market can be improved. That's why we've updated the premier intumescent Firestop Sealant FS-ONE to Hilti Firestop Sealant FS-ONE MAX. With an extended shelf life, improved handling and an ethylene glycol-free composition, FS-ONE MAX is the next generation of intumescent firestop sealant.

FS-ONE MAX directly replaces Hilti Firestop Sealant FS-ONE. In addition, all of our UL systems have been updated to reflect the new, improved FS-ONE MAX. That means you'll now find more than 600 UL systems to help protect combustible and non-combustible penetrations for up to 4 hours of fire rating.



Applications

- Seal most common through penetrations in a variety of base materials
- Use on concrete, masonry and drywall
- Use with mixed and multiple penetrations
- Seal metal pipe penetrations: copper, steel and EMT
- Seal insulated metal pipe penetrations: steel and copper

Advantages

- Versatile: an intumescent firestop sealant for a wide variety of penetrations
- Effective: smoke, gas and water resistant
- Workable: water-based material is easy to dispense and apply
- Paintable: trowel to a smooth finish
- Storable: long shelf life
- Cleaner: ethylene glycol-free

- Flexible: W-rated systems available
- American: satisfies Buy American standards

EASILY SUBSTITUTE - AND UPGRADE

Download the substitution letter to include in your submittal.

Create a submittal with our online submittal generator tool.

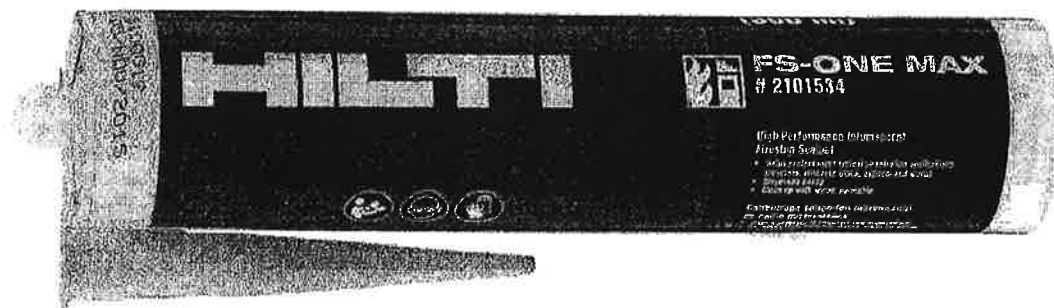
TESTING IN ONGOING

Find the most up-to-date UL listings using the **Hilti UL Selector**

UPGRADE YOUR SPECIFICATION TEXT TO INCLUDE FS-ONE MAX

Download the relevant specification sections

SHOP NOW



FS-ONE MAX

High-performance intumescent firestop sealant

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eirmod tempor invidunt ut labore et dolore magna aliquyam erat, sed diam
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Hilti USA

Service Hotline: (800) 879-8000

CERTIFICATE OF COMPLIANCE

Certificate Number 20150108-R13240
Report Reference R13240
Issue Date 2015-January-08

Issued to: Hilti Construction Chemicals, Div of Hilti Inc.
5400 S 122nd East Ave
Tulsa, OK 74146


This is to certify that representative samples of Fill, Void or Cavity Materials
Fill, Void or Cavity Materials Certified for Canada
FS-ONE MAX Intumescent Sealant for use in Through-
Penetration Firestop and Joint Systems in the UL Fire
Resistance Directory and in the Products Certified for
Canada Directory.

Have been investigated by UL in accordance with the
Standard(s) indicated on this Certificate.

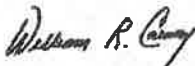
Standard(s) for Safety: ANSI/UL 1479, "Fire Tests of Through-Penetration
Firestops," – Edition 4
ANSI/UL 2079, "Tests for Fire Resistance of Building Joint
Systems," – Edition 4 – Revision Date 2014/12/17
CAN/ULC-S115, "Standard Method of Fire Tests of Firestop
Systems," – Edition 4 – Issue Date 2011/06/01

Additional Information: See the UL Online Certifications Directory at
www.ul.com/database for additional information

Only those products bearing the UL Classification Mark should be considered as being covered by
UL's Classification and Follow-Up Service.

The UL Classification Mark includes: UL in a circle: with the word "CLASSIFIED"  (as shown); a control
number (may be alphanumeric) assigned by UL; a statement to indicate the extent of UL's evaluation of
the product; and the product category name (product identity) as indicated in the appropriate UL
Directory.

Look for the UL Classification Mark on the product.



William R. Carney, Director, North American Certification Programs
UL LLC

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contact a local UL Customer Service Representative at www.ul.com/contactus



Retrofit Sleeve Kit CFS-SL RK

Product description

- Retrofit cable management device for easily and safely firestopping existing cable applications
- Offered in 2" and 4" diameter versions
- Standard kit includes (1) retrofit sleeve (2) retrofit flanges with smoke seal (2) Firestop Plugs CFS-PL

Product features

- Fast and easy installation for existing cables with ability to re-penetrate
- Integrated smoke seal eliminates the need to add sealant behind the flange
- Oversized flanges for irregular and large openings
- Pre-cured, pre-formed firestop material does not expire, eliminating shelf-life concerns
- Protects most typical firestop cable applications
- 4" diameter device is compatible with the Hilti Gangplate (CFS-SL GP)
- Buy American compliant
- Meets LEED™ requirements for indoor environmental quality credit 4.1 Low Emitting Materials, Sealants and Adhesives
- Low VOC content and no CFCs or HCFCs

Areas of application

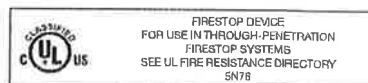
- Single and bundled cables in gypsum and CMU walls

Examples

- Safely firestopping existing cable applications in fire rated walls, especially where future re-penetration is needed



Technical Data	CFS-SL RK
2" Device	Sleeve: OD 2.5 in / ID 2.3 in Flange: OD 8 in
4" Device	Sleeve: OD 4.5 in / ID 4.3 in Flange: OD 10 in
Overall sleeve length	10.5 in
Expansion ratio (unrestricted)	Approx. 1:3
Temperature resistance	5° F to 140° F (-15° C to 60° C)
Intumescent activation	Approx. 392° F (200° C)
Surface burning characteristics (ASTM E 84-10b)	Flame Spread: 10 Smoke Development: 15
Tested in accordance with	ASTM E 814 CAN/ULC-S115 UL 1479 ASTM E 84 (CFS-PL only)



Installation instructions for Firestop Retrofit Sleeve Kit

See Hilti Literature or third-party listings for complete application and installation details



Hilti Firestop
Saving lives
through innovation
and education

Hilti. Outperform. Outlast.

Hilti, Inc. (U.S.) 1-800-879-8000 www.us.hilti.com • www.us.hilti.com/firestop • on español 1-800-879-5000

ORIGIN ID: JOTA (709) 478-7030 VIRGINIA ODEGAARD MURER CONSULTANTS, INC. 19085 HICKORY CREEK DR. SUITE 115 MOKENA, IL 60448 UNITED STATES US	SHIP DATE: 03MAR17 ACTWGT: 0.50 LB CAD: 531325ZINET3850 BILL SENDER
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Maupin, Susan

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Sent: Monday, March 06, 2017 9:11 AM
To: Maupin, Susan
Subject: FedEx Shipment 778572088111 Delivered

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Your package has been delivered

Tracking # 778572088111

Ship date:
Fri, 3/3/2017

Virginia Odegaard
MURER CONSULTANTS, INC
MOKENA, IL 60448
US

Delivery date:
Mon, 3/6/2017 9:08 am

Kathy Zeigler, RN
West TN Health Care Facilities
2975 C Highway 45 Bypass
Department of Health
JACKSON, TN 38305
US

 Delivered

Shipment Facts

Our records indicate that the following package has been delivered.

Tracking number: 778572088111

Status: Delivered: 03/06/2017 09:08
AM Signed for By:
B.STRICKLAND

Reference: 13038

Signed for by: B.STRICKLAND

Delivery location: JACKSON, TN

Delivered to: Receptionist/Front Desk

Service type: FedEx Priority Overnight


Packaging type: FedEx Envelope

Number of pieces: 1

Weight: 0.50 lb.

Special handling/Services: Deliver Weekday

Standard transit: 3/6/2017 by 10:30 am

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Tre Hargett
Secretary of State

Division of Business Services
Department of State

State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **Regional Med Extended Care Hospital LLC**

General Information

SOS Control #	000512916	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	02/08/2006
	02/08/2006 10:55 AM	Fiscal Year Close	12
Status:	Active	Member Count:	1
Duration Term:	Expires: 12/31/2045		
Managed By:	Director Managed		

Registered Agent Address

MONICA N WHARTON
877 JEFFERSON AVE
MEMPHIS, TN 38103-2807

Principal Address

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MEMPHIS, TN 38103-2807

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<u>Date Filed</u>	<u>Filing Description</u>	<u>Image #</u>
03/16/2017	2016 Annual Report	B0361-6405
	Member Count Changed From: 5 To: 1	
03/30/2016	2015 Annual Report	B0212-5727
03/26/2015	2014 Annual Report	B0077-0305
	Member Count Changed From: 1 To: 5	
05/07/2014	Assumed Name	7340-1671
	New Assumed Name Changed From: No Value To: Regional One Health Extended Care Hospital	
03/31/2014	2013 Annual Report	7315-1002
06/07/2013	Articles of Amendment	7212-0729
	Filing Name Changed From: MEMPHIS LONG TERM CARE SPECIALITY HOSPITAL LLC To: Regional Med Extended Care Hospital LLC	
	Principal Address 3 Changed From: MONICA N. WHARTON, ESQ. To: No value	
06/06/2013	2012 Annual Report	A0188-1952
	Principal Address 1 Changed From: 3391 OLD GETWELL RD To: 877 JEFFERSON AVE	
	Principal Address 3 Changed From: No value To: MONICA N. WHARTON, ESQ.	
	Principal Postal Code Changed From: 38118-3635 To: 38103-2807	
	Managed By Changed From: Member Managed To: Director Managed	

Filing Information

Name: Regional Med Extended Care Hospital LLC

Registered Agent First Name Changed From: MICHAEL To: MONICA	
Registered Agent Middle Name Changed From: D To: N	
Registered Agent Last Name Changed From: BRENT To: WHARTON	
Registered Agent Physical Address 1 Changed From: 1600 DIVISION ST To: 877 JEFFERSON AVE	
Registered Agent Physical Address 2 Changed From: STE 700 To: No Value	
Registered Agent Physical City Changed From: NASHVILLE To: MEMPHIS	
Registered Agent Physical County Changed From: DAVIDSON COUNTY To: SHELBY COUNTY	
Registered Agent Physical Postal Code Changed From: 37203-2771 To: 38103-2807	
06/04/2013 Notice of Determination	A0180-1641
09/07/2012 2010 Annual Report	7094-0179
Principal Postal Code Changed From: 38118 To: 38118-3635	
09/07/2012 2011 Annual Report	7094-0180
09/07/2012 Application for Reinstatement	7094-0181
Filing Status Changed From: Inactive - Dissolved (Administrative) To: Active	
Inactive Date Changed From: 08/09/2011 To: No Value	
08/09/2011 Dissolution/Revocation - Administrative	A0088-2488
Filing Status Changed From: Active To: Inactive - Dissolved (Administrative)	
Inactive Date Changed From: No Value To: 08/09/2011	
06/02/2011 Notice of Determination	A0076-0749
09/10/2010 Application for Reinstatement	6768-2014
Filing Status Changed From: Inactive - Dissolved (Administrative) To: Active	
Inactive Date Changed From: 08/08/2010 To: No Value	
09/10/2010 2009 Annual Report	6768-2013
08/08/2010 Dissolution/Revocation - Administrative	A0040-3155
Filing Status Changed From: Active To: Inactive - Dissolved (Administrative)	
06/03/2010 Notice of Determination	A0026-0821
11/05/2009 2008 Annual Report	6620-1300
10/09/2009 Notice of Determination	A0001-0756
02/20/2009 Application for Reinstatement	6450-1902
02/20/2009 2007 Annual Report	6450-1901
04/02/2008 Dissolution/Revocation - Revenue	6278-0325
11/21/2007 Assumed Name	6160-1057
09/20/2007 Common Amendment	6130-1314
09/18/2007 Application for Reinstatement	6130-0657
09/18/2007 2006 Annual Report	6130-0656
08/27/2007 Dissolution/Revocation - Administrative	ROLL 6097

Filing Information

Name: **Regional Med Extended Care Hospital LLC**

06/21/2007 Notice of Determination ROLL 6065

05/17/2007 Articles of Amendment 6059-0458

Name Changed

02/08/2006 Initial Filing 5674-2173

Active Assumed Names (if any)

	Date	Expires
Regional One Health Extended Care Hospital	05/07/2014	05/07/2019



Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **SHELBY COUNTY HEALTH CARE CORPORATION**

General Information

SOS Control #	000104378	Formation Locale:	TENNESSEE
Filing Type:	Nonprofit Corporation - Domestic	Date Formed:	06/15/1981
	06/15/1981 4:30 PM	Fiscal Year Close	6
Status:	Active		
Duration Term:	Perpetual		
Public/Mutual Benefit:	Public		

Registered Agent Address

MONICA N WHARTON
877 JEFFERSON AVE
MEMPHIS, TN 38103-2807

Principal Address

MONICA N. WHARTON
877 JEFFERSON AVE
MEMPHIS, TN 38103-2807

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
12/06/2016	Assumed Name	B0319-9264
	New Assumed Name Changed From: No Value To: Regional One Health Rehabilitation Hospital	
09/13/2016	2016 Annual Report	B0280-7817
02/26/2016	Assumed Name Renewal	B0205-1805
	Assumed Name Changed From: Regional Medical Center at Memphis To: Regional Medical Center at Memphis	
	Expiration Date Changed From: 04/11/2016 To: 02/26/2021	
08/28/2015	2015 Annual Report	B0137-4831
05/28/2015	Assumed Name	B0104-3553
	New Assumed Name Changed From: No Value To: Regional One Health Subacute Care	
09/24/2014	2014 Annual Report	B0006-5152
	Principal Address 3 Changed From: No value To: MONICA N. WHARTON	
09/17/2014	Amended and Restated Formation Documents	B0003-2481
	Principal Address 3 Changed From: MONICA N. WHARTON To: No value	
02/27/2014	Assumed Name	7293-0230
	New Assumed Name Changed From: No Value To: Regional Medical Center	
02/20/2014	Assumed Name	7289-0207
	New Assumed Name Changed From: No Value To: Regional One Health	

Filing Information

Name: **SHELBY COUNTY HEALTH CARE CORPORATION**

11/05/2013 2013 Annual Report	7251-1644
09/18/2012 2012 Annual Report	7096-0422
Principal Address 3 Changed From: No value To: MONICA N. WHARTON	
02/21/2012 Amended and Restated Formation Documents	6999-2738
Principal Address 1 Changed From: 877 JEFFERSON AVENUE To: 877 JEFFERSON AVE	
Principal Postal Code Changed From: 38103 To: 38103-2807	
09/29/2011 2011 Annual Report	6943-1870
04/11/2011 Assumed Name Renewal	6877-2034
Assumed Name Changed From: THE REGIONAL MEDICAL CENTER AT MEMPHIS To: THE REGIONAL MEDICAL CENTER AT MEMPHIS	
Expiration Date Changed From: 05/23/2011 To: 04/11/2016	
04/11/2011 Assumed Name Change	6883-0157
Assumed Name Cancelled Changed From: No Value To: THE REGIONAL MEDICAL CENTER AT MEMPHIS	
New Assumed Name Changed From: No Value To: Regional Medical Center at Memphis	
09/30/2010 2010 Annual Report	6776-3221
10/07/2009 2009 Annual Report	6609-2422
11/10/2008 Registered Agent Change (by Entity)	6398-1272
Registered Agent Changed	
08/07/2008 2008 Annual Report	6360-1232
06/27/2007 2007 Annual Report	6080-2141
06/11/2007 Amended and Restated Formation Documents	6071-1204
01/16/2007 2006 Annual Report	5917-0341
12/01/2006 Notice of Determination	ROLL 5893
05/23/2006 Assumed Name	5797-0604
02/01/2006 2005 Annual Report	5673-1570
12/01/2005 Notice of Determination	ROLL 5617
10/04/2004 2004 Annual Report	5248-1491
12/11/2003 2003 Annual Report	4982-0725
12/11/2003 Assumed Name	4982-0727
07/03/2003 Assumed Name	4855-1512
07/05/2002 2002 Annual Report	4544-0739
02/05/2002 2001 Annual Report	4412-3028
12/21/2001 Notice of Determination	ROLL 4376
08/01/2000 2000 Annual Report	3966-0242
12/31/1998 Merger	3601-2051
Merged Control # Changed From: 000104378	
8/11/2017 8:32:30 AM	

Filing Information

Name: **SHELBY COUNTY HEALTH CARE CORPORATION**

Merged Control # Changed From: 000270481	
12/31/1998 Merger	3601-2054
Merged Control # Changed From: 000104378	
Merged Control # Changed From: 000222713	
09/09/1998 Assumed Name Renewal	3558-2965
03/11/1998 CMS Annual Report Update	3467-0972
Registered Agent Changed	
12/19/1997 Notice of Determination	ROLL 3425
03/25/1996 Registered Agent Change (by Entity)	3144-0010
Registered Agent Physical Address Changed	
Registered Agent Changed	
03/07/1995 Registered Agent Change (by Agent)	2970-0379
Registered Agent Physical Address Changed	
12/17/1993 Notice of Determination	ROLL 2766
10/18/1993 Assumed Name	2747-0136
08/30/1991 CMS Annual Report Update	2256-0987
Mail Address Changed	
10/22/1990 Articles of Amendment	1971-0675
Principal Address Changed	
Registered Agent Physical Address Changed	
05/10/1990 Common Amendment	1762-1040
03/16/1990 Dissolution/Revocation - Administrative	ROLL 1685
12/29/1989 Administrative Amendment	1580-1741
Mail Address Changed	
12/15/1989 Notice of Determination	ROLL 1577
08/04/1988 Assumed Name	906-0005
05/13/1986 Articles of Amendment	611 01687
05/10/1985 Articles of Amendment	542 01037
07/15/1981 Articles of Amendment	219 01080
06/15/1981 Initial Filing	215 00147

Active Assumed Names (if any)

	<u>Date</u>	<u>Expires</u>
Regional One Health Rehabilitation Hospital	12/06/2016	12/06/2021
Regional One Health Subacute Care	05/28/2015	05/28/2020
Regional Medical Center	02/27/2014	02/27/2019
Regional One Health	02/20/2014	02/20/2019
Regional Medical Center at Memphis	04/20/2011	02/26/2021

MANAGEMENT SERVICES AGREEMENT LONG TERM ACUTE CARE HOSPITAL

THIS MANAGEMENT SERVICES AGREEMENT ("Agreement") is made and entered into as of the _____ day of _____ (the "Effective Date") by and between REGIONAL MED EXTENDED CARE HOSPITAL, LLC, Memphis, Tennessee ("Client") and MURER CONSULTANTS, INC. Joliet, Illinois ("Manager").

RECITALS:

WHEREAS, Client seeks to assure effective operation of the long-term acute care hospital ("Hospital")

WHEREAS, the Client wishes to assure that the Hospital is provided with: (1) high quality management services through a firm with extensive long-term acute care experience; (2) clinical services that encompass the full spectrum of long-term acute care; (3) efficient and effective use of the Hospital's equipment; (3) clinical program development and diversity; (4) clinical and administrative staffing appropriate for bed size, license and certification of the long-term acute care hospital; and (5) Medical Staff credentialing and management, all of which are designed to develop and enhance the overall quality of patient care at the Hospital;

WHEREAS, the Client, acting in the best interest of the Hospital's patient population, the community, the Hospital's Medical Staff, and itself, has determined that the best way to attain these objectives is to enter into a contract with Murer Consultants as Manager to provide operational management and clinical services to the Hospital;

WHEREAS, Manager has the requisite knowledge and experience to provide the necessary operational and management services, on the terms and conditions set forth in this Agreement;

NOW THEREFORE, in consideration of the mutual covenants and conditions contained herein and for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

- 1. Appointment.** The Client hereby appoints the Manager, and the Manager hereby accepts such appointment, to provide operational management at the Hospital during the term of this Agreement and any renewal terms hereof, on the terms and conditions set forth in this Agreement. The Manager acknowledges that the purpose in entering into this Agreement is to ensure high quality long-

term acute care services are provided by the Hospital and a positive reputation for quality of service provided by the Hospital in the medical community and service area is maintained.

2. **Mutual Understanding of Relationship.** Client hereby appoints Manager to supervise, operate and manage Hospital in the name, for the account, and on behalf of Client pursuant and subject to the terms and conditions set forth in this Agreement. Manager will utilize the skills of its management staff to operate Hospital in a reasonably economical and efficient manner and will devote the necessary time and energy to such management as necessary.

This appointment of and acceptance by Manager for the management of Hospital shall be for Manager acting as an Independent Contractor to Client. In furtherance thereof, Client and Manager, covenant and agree that neither is the employee, employer, principal, nor agent of the other except that Manager is in the status of an Independent Contractor to Client.

Client acknowledges and agrees that whereas Manager has accepted the function of overseeing, managing and operating Hospital, except as specifically set forth herein to the contrary or as provided by law, Manager is responsible for the operation and management of Hospital and for establishing and implementing Hospital's operating policies and standards of operation, services, maintenance, pricing, and other policies affecting Hospital or the operation thereof. In addition, Manager shall be entitled to rely upon written instructions received from a duly authorized designee of Client as to any and all acts to be performed by Manager consistent with this Agreement.

3. **The Client's Duties**

- (a) **Space.** The Client shall provide adequate space and utilities necessary for the long-term acute care hospital, including such space necessary for (1) patient care; (2) nursing; (3) administrative staff; and (4) medical records and any and all other space requirements mandated by Federal or State regulations.
- (b) **Supplies and Equipment.** The Client will provide all necessary supplies and equipment necessary and sufficient for the efficient provision of long-term acute care services.
- (c) **Contracted Services.** The Hospital will enter into such vendor agreements with The Regional Medical Center of Memphis (The MED), as well as any other appropriate outside vendors as necessary to provide additional ancillary and support services for the Hospital. Contracted Services typically include, but are not limited to, the following:

1. Biomedical Services
2. Blood Services
3. Central Supply
4. Chemotherapy
5. Credentialing Services
6. Dialysis
7. Dietary
8. Financial, Accounting and Payroll Services
9. Housekeeping
10. Laboratory Services
11. Laundry
12. Radiation Therapy
13. Radiology, Imaging and Ultrasound Services
14. Rehabilitation Therapy Services
15. Security Services
16. Surgical Services

4. The Manager's Duties. The Manager will provide a full range of operational management services, including, but not limited to, the following:

(a) Six Month Data Collection Process. The Manager shall oversee the data collection process during the first six months of operation. Duties shall include:

1. Monitor the new entity under the regulatory mandates for a six (6) month data collection period prior to Medicare classification and designation as a long term acute care hospital.
2. Direct and oversee procedures for the six (6) month data collection period necessary for documentation of the average length of stay necessary for certification as a long term acute care hospital and to assure appropriate management and identification of cross-over patients.
3. Submit requisite documentation in keeping with Federal guidelines regarding the six months data collection.
4. Serve as liaison with the fiscal intermediary and CMS through receipt of the LTACH provider number.

(b) Administrative Oversight. The Manager shall oversee the performance and day-to-day activities of an Administrator, subject to the approval of the Client who will report directly to the Manager but whose salary and benefits shall be paid through the Hospital as a direct expense. Duties shall include:

1. Establishing a budget for approval by the Hospital's Board of Directors, monitoring expenses and evaluating the utilization of services;
2. Preparing monthly status reports regarding the performance of the Hospital;
3. Assisting and advising the Hospital's Board of Directors in the preparation of any information and/or data necessary for continued accreditation, certification, licensure, and survey by voluntary, local, state, and national organizations;
4. Assisting and making recommendations to the Hospital's Board of Directors regarding the implementation of a strategy and plan for marketing the services of the Hospital to the medical staff of The MED and other local physicians and providers;
5. Continuing education of medical and clinical staff, as required by the demands of the Hospital, to maintain professional excellence;
6. Developing and implementing appropriate staffing plans according to the needs of the Hospital;
7. Representing and promoting the Hospital in the community to enhance the visibility and standing of the Hospital;
8. Establishing standards for policies and procedures within the Hospital which are in compliance with federal regulations, Medicare Conditions of Participation for long term acute care hospitals and state hospital licensure requirements;
9. Establishing and negotiating third party payer contracts on behalf of the Hospital and in conjunction with and in complement to The MED.

(c) **Staffing.** The Manager shall oversee recruitment and staffing for all positions. The Manager shall submit a staffing plan for approval prior to the beginning of each fiscal year or at any time requested by Client. The staff will be of adequate size and ability to operate the Hospital.

Subject to the policies and direction of Client, Manager shall have the responsibility and authority to employ, train, promote, direct and terminate the employment of Hospital employees needed for the operation of all departments and services of the facility. Subject to policies and direction of Client, Manager shall also have the responsibility and authority to

recommend wages and salaries for Hospital employees, in concert with the competitive market. Manager shall further have the responsibility and authority to establish performance standards and personnel policies in concert with and with support of the health system.

The staff will include, but not be limited to, the Administrator, a Chief Nursing Officer, a Chief Medical Officer, Nursing Staff, Respiratory Therapists, Pharmacy Staff, Case Managers, Social Worker, medical records personnel, a quality assurance manager, an infection control manager, and clerical support.

The three key management individuals of **Administrator, Chief Nursing Officer and Chief Medical Officer** shall report directly to the Manager. All other personnel shall appropriately report through LTACH administrative staff as per the LTACH organizational chart.

All Hospital salaries and benefits, including those paid to the Administrator, Chief Nursing Officer, Chief Medical Officer and other staff, shall be paid as a direct expense by Client.

- (d) **Consultation.** The Manager will be available for consultation with the Hospital's Medical Staff with respect to medical and organizational matters and to the Hospital's Board of Directors regarding operational or governance issues.
- (e) **Management Services.** The Manager shall oversee the performance of the key management functions and services of the Hospital, including, but not limited to, the following:
 - 1. Administration;
 - 2. Medical Staff Credentialing;
 - 3. Medical Records;
 - 4. Quality Assurance / Improvement;
 - 5. Human Resources;
 - 6. Infection Control;
 - 7. Corporate and Legal Compliance;
 - 8. Marketing;
 - 9. Mission Integration;
 - 10. Nursing;
 - 11. Respiratory Therapy;
 - 12. Physical Medicine (PT, OT, Speech);
 - 13. Pharmacy;
 - 14. Basic Laboratory;
 - 15. Basic Radiology; and
 - 16. Social Services
 - 17. Case Management

18. Financial and Accounting Services
19. Billing and Collection
20. Insurance
21. Risk Management
22. Other services as directly related to day to day operation of the specialty hospital

(f) **Limitations on Manager's Authority.** The Manager shall not have the authority to take the following actions without approval from Client's Board of Trustees:

1. Enter into or terminate contracts with physicians on behalf of Client, except as Client may specifically authorize.
2. Purchase or lease capital assets without the prior approval of Client.
3. Negotiate or enter into collective bargaining agreements covering or purporting to cover employees of Client.
4. Enter into settlement negotiations or conduct other litigation-related activities without the consent of Client.

(g) **Clinical Program Development.** The Manager, in conjunction with the Hospital Medical Staff and Chief Medical Officer, shall develop and implement clinical policies and procedures for use in relevant clinical areas.

(h) **Records Maintenance.** The Manager will maintain accurate and complete patient records and maintain written reports pursuant to all standards established from time to time by Medicare, Medicaid, The Joint Commission, all other applicable accrediting organizations, and the Medical Staff bylaws, rules, regulations, and policies, with all such reports and records to be and remain the property of the Client; provided, however, that the Manager will have the right of reasonable access to such records and reports for any valid reasons relating to medical and professional liability.

(i) **Quality.** All clinical and administrative services provided by the Manager under this Agreement will be in accordance with the Hospital's bylaws and Rules and Regulations promulgated pursuant hereto, together with all rules, regulations and standards promulgated by The Joint Commission, the Department of Health and Human Services, the Centers for Medicare and Medicaid, the State Department of Health and Human Services, the conditions of participation under the applicable Medicare and Medicaid regulations, including, but not limited to those pertaining to long-term care hospitals within hospitals, and all other organizational or governmental bodies with authority over the Client and the Hospital.

Manager shall cooperate and maintain liaison with the Medical Staff of Hospital and shall advise and assist the Medical Staff in functioning in the manner provided by the standards and guidelines on accreditation. Manager shall assist the Medical Staff in adopting and reviewing bylaws and shall advise the Medical Staff regarding procedural matters; however, medical, ethical and professional matters shall be the responsibility of Client and Medical Staff of the Hospital with appropriate input from Manager.

Upon the request of Client and the Medical Staff of Hospital, Manager shall make available and assist in the implementation of a Quality Assurance Program. Implementation services shall include assistance with preparation of forms and other documentation, training of quality assurance personnel and the holding of orientation sessions for members of the Medical Staff. Manager's Quality Assurance Program and implementation services shall comply with the Health Care Quality Improvement Act of 1986 and with any applicable state peer review protection law.

(j) **Additional Manager Deliverables.** In addition to the aforementioned services to be provided by the Manager, other specific deliverables shall be provided. These deliverables include, but are not limited to, the following:

1. Development of a Corporate Compliance Plan (consistent with The MED's Corporate Compliance Plan) including Annual Training and Plan Review
2. Establishment and Maintenance of Compliance with federal, state, and other regulatory requirements including, but not limited to:
 - a) Conditions of Participation for a long-term acute care hospital under applicable Medicare regulations
 - b) State hospital licensure requirements
3. Provision, inclusion and annual review of policies and procedures/documents necessary for the operation of the Hospital, including:
 - a) Administrative Policies and Procedures
 - b) General Clinical Policies and Procedures
 - c) Medical Staff Bylaws
 - d) Chief Medical Officer Contract
 - e) Lease Agreement

- f) Ancillary Services / Vendor Agreements
 - g) Hospital Bylaws
- 4. Quality Management Program;
- 5. Annual Professional Continuing Education Programs for clinical and non-clinical staff;
- 6. Coordination of Board Functions, including
 - a) Preparation of board packets
 - b) Attendance at board meeting to present quarterly management report
 - c) Taking and transcribing minutes of board meetings
- 7. Coordination of Medical Staff functions, including:
 - a) Medical Staff Credentialing
 - b) Medical Staff Relations
 - c) Medical Staff Committee Structure
 - d) Medical Records Compliance;
- 8. Human Resource Programs / Functions including:
 - a) Recruitment of administrative and clinical staff
 - b) Standardized job descriptions
 - c) Performance appraisals
 - d) Competency certification / continuing education
- 9. Case Management Program to monitor The MED's referrals relative to appropriateness and timeliness of admission;
- 10. Concurrent utilization review through weekly analysis of patient LOS and working DRG;
- 11. Annual DRG analysis of co-located hospital to monitor financial impact of the Hospital and assess effectiveness of patient referral process;
- 12. Participation in system-wide networking/leadership forums for Medical Director(s), Clinical/Support Services Managers and Administrative team members;
- 13. Annual chart review to assess quality of documentation in conformance with federal regulations;

- (k) **Reports Due.** The Manager shall provide quarterly status reports regarding the overall operation of the Hospital to the Hospital's Board of Directors. The Manager shall also prepare Board packets and will maintain minutes of each Board meeting as well as preparation of an annual report for the Hospital's Board of Directors identifying goals and benchmarks for the forthcoming year.

5. Management Fee

In consideration of Manager's obligations under this Agreement, Client shall pay Manager a monthly fee ("Management Fee") for the Management Services provided by Manager during the term hereof. The Management Fee of Three Hundred Thousand Dollars (\$300,000) per annum shall be payable in twelve equal monthly payments of Twenty Five Thousand Dollars (\$25,000) per month with a 3% increase annually, years two – three (2-3). Payment of the Management Fee shall begin on the Effective Date and be payable on the first day of each succeeding month.

Manager shall be reimbursed for reasonable out of pocket expenses for mailing, duplicating, travel and on-site expenses such as meals, lodging, and ground transportation.

6. Assignment/Reassignment of Lead Consultant

Manager's President and CEO, Cherilyn Murer, will have overall accountability for the quality and value of Manager's services to the Hospital, and will have overall responsibility for coordination of key initiatives pursued through this Agreement and for Manager's performance of its duties under this Agreement. Cherilyn Murer, or her designee, shall attend the quarterly board meetings and shall attend such other meetings as may be necessary to affect the intent of this Agreement. In the event Manager is acquired or merges with another entity, and Ms. Murer is no longer in the position to serve as lead consultant, Hospital will, on this project, have 180 days to evaluate the successor. At any time following the 120th day and before the 180th day, should Hospital determine that the successor is not acceptable, Hospital may terminate this agreement immediately by giving written notice to Manager. As an alternative to termination of this Agreement, Hospital may require Manager to remove and replace such Manager's Lead Consultant with another candidate, subject to Hospital's approval.

7. Term and Termination

- (a) **Term.** This Agreement will commence on the date first written above and will continue in effect for an initial period of three (3) years. Thereafter, the

Agreement may be renewed by a written amendment hereto signed by authorized representatives of both parties.

(b) Termination by Manager. Manager will be allowed to automatically terminate this agreement in the event of:

1. Client becomes insolvent (as that term is defined for purposes of the United States Bankruptcy Code), files or has filed against it a petition in bankruptcy, make a general assignment of its assets for the benefit of its creditors, or ceases to do business;
2. Client fails to pay the Management Fee, within 30 days of the applicable due date, due under this Agreement;
3. Failure of Client to comply with its obligations set forth in this Agreement provided Manager has given Client written notice of such default of obligation, and Client has had sixty (60) days to correct such default. However, if such default cannot be reasonably cured within sixty (60) days, Manager shall not terminate this Agreement if Client has commenced to cure such default within sixty (60) days, to the reasonable satisfaction of Manager and thereafter continues diligently to cure such breach.

(c) Termination by Client. Client will be allowed to automatically terminate this agreement in the event of:

1. Manager becomes insolvent (as that term is defined for purposes of the United States Bankruptcy Code), files or has filed against it a petition in bankruptcy, make a general assignment of its assets for the benefit of its creditors, or ceases to do business;
2. Hospital loses or does not obtain its Medicare Certification and classification as a long term acute care hospital;
3. Cause related to failure of Manager to comply with its obligations set forth in this Agreement provided Client has given Manager written notice of such default of obligation, and Manager has had 60 days to correct such default. However, if such default cannot be reasonably cured within 60 days, Client shall not terminate this Agreement if Manager has commenced to cure such default within 60 days, to the reasonable satisfaction of Client and thereafter continues diligently to cure such breach.
4. Manager commits any act of fraud, misappropriation or embezzlement, or any other felony and as a result the Manager is unable to substantially perform under the terms of this Agreement.

- (d) **Compensation Upon Termination.** Upon termination of this Agreement for any reason, Manager will be entitled to receive the Management Fee and any other amounts due Manager accrued through the date of termination, and Client shall continue to abide by the terms of this contract until all Management Fees are fully paid.

8. Insurance and Indemnification.

- (a) **Insurance.** Manager will, at all times maintain liability insurance in an amount not less than one million dollars per occurrence and three million dollars in the aggregate and will provide written evidence of such insurance upon request.
- (b) **Indemnification.** Each party will indemnify and hold the other harmless from any and all loss or liability, to the extent not covered by insurance, directly arising out of any failure to perform this Agreement in accordance with its terms.
- (c) **Notice of Change.** Manager shall provide Client immediate written notification if Manager changes the company or firm through which such insurance is maintained.

8. General Provisions.

- (a) **Entire Agreement.** This Agreement, together with any schedules or exhibits constitutes the entire agreement with respect to Management Services and supersedes all prior proposals, oral and written, negotiations, representations, communications, writings, agreements, and communications between Client and Manager.
- (b) **Assignment.** Neither party shall assign or transfer its rights or obligations under this Agreement except with the other party's prior written consent.
- (c) **Binding Effect.** This agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and assigns.
- (d) **Governing Law Venue.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of Tennessee. The parties agree that any legal action or proceeding with respect to this Agreement shall be brought in the United States District Court for the Western District of Tennessee, or, if such court does not have jurisdiction, in any court of general jurisdiction in Shelby County, Tennessee. Manager consents to the personal jurisdiction of such courts, agrees to

accept service of process by mail and hereby waives any jurisdictional or venue defenses otherwise available to it.

- (e) **Amendments.** This Agreement may only be amended or modified by subsequent written agreement between duly authorized representatives of Client and Manager.
- (f) **Access to Records.** During the term of this Agreement and for a period of four (4) years thereafter, Manager and Client will, upon request, make available to the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any books, documents or records necessary to verify the nature and extent of costs incurred pursuant to this Agreement.

If the Manager carries out any of the duties of this Agreement with a value of Ten Thousand Dollars (\$10,000) or more over a twelve (12) month period through a subcontract with a related organization, it must be approved by Client and must contain a clause to the effect that until the expiration of four (4) years after furnishing of services under such subcontract, the related organization shall make available, upon written request to the Secretary of Health and Human Services, the United States Comptroller General, or any of their duly authorized representatives, the subcontract and books, documents and records of the related organization that are necessary to verify the nature and extent of costs incurred by the Manager and Client under the subcontract.

- (g) **Section Headings.** The headings of paragraphs in this Agreement are for reference only and shall not affect the meaning of this Agreement.
- (h) **Notice.** Any notices or other communications required or contemplated under the provisions of this Agreement shall be in writing and delivered in person, evidenced by a signed receipt, or mailed by certified mail, return receipt requested, postage prepaid, to the persons and addresses indicated below or to such other persons or addresses as Client and Manager may provide by written notice to the other. The date of notice shall be the date of delivery if the notice is personally delivered or the date of mailing if the notice is mailed by certified mail.
- (i) **Severability.** The provisions of this Agreement shall be deemed severable and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding upon the Parties.
- (j) **Counterparts.** This Agreement may be executed in counterparts, each of which shall be deemed to be an original.

- (k) **Confidential Information.** Manager agrees that it shall not during or after termination of this Agreement, use for itself or others, or disclose to others, trade secrets, patient information, marketing plans or other private or confidential information of or about Hospital that is not already available to the public without Hospital's prior written permission.
- (l) **Compliance with HIPAA.** Each party shall comply with all applicable rules, regulations, and accreditation standards or requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as the same may be amended from time to time.
- (m) **Notices.** Any notice, demand, or communication required, permitted, or desired to be given hereunder, shall be deemed effectively given when personally delivered or delivered by overnight courier service or mailed by prepaid certified mail, return receipt requested, addressed as follows:

CLIENT

Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

MANAGER

Murer Consultants, Inc.
58 N. Chicago Street, 7th Floor
Joliet, IL 60432

Attn: Bret Perisho, VP
Strategic Business Dev.

Attn: Michael Murer, EVP
General Counsel

CC: Monica Wharton, Senior VP
Chief Legal Officer and General Counsel

or to such other address, and to the attention of such other person(s) or officer(s) as either party may designate by written notice.

- (n) **Representations and Warranties.** Manager and Client warrant by execution of this Agreement that neither Manager, nor Client, nor any agent or employee of Manager or Client (i) is to its knowledge being investigated, (ii) has been convicted of a health care statutory crime, or (iii) has been sanctioned in any way by the Department of Health and Human Services ("HHS"), the HHS office of the Inspector General ("OIG"), or the Center for Medicare and Medicaid Services ("CMS"). Manager and Client shall immediately notify Client or Manager, respectively, if Manager or Client or any agent or employee of Manager or Client is convicted of a healthcare statutory crime or is sanctioned in any way by the HHS, OIG, or CMS.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.

REGIONAL MEDICAL CENTER AT MEMPHIS

Memphis, Tennessee

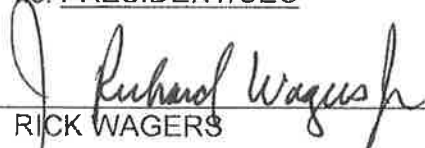
On Behalf of REGIONAL MED EXTENDED CARE HOSPITAL, LLC

(To be ratified at initial meeting of the Board of Director)

By: 
REGINALD COOPWOOD, MD

8/9/2013
DATE

Its: PRESIDENT/CEO

By: 
RICK WAGERS

8-12-13
DATE

Its: CHIEF FINANCIAL OFFICER

MURER CONSULTANTS, INC.

Joliet, Illinois

By: 
CHERYLYN G. MURER, JD, CRA

8/2/13
DATE

Its: PRESIDENT / CEO

REGIONAL MED EXTENDED CARE HOSPITAL LEASE AGREEMENT

Prepared By Murer Consultants, Inc.

This Lease agreement (the "Lease") is made and entered into this 23rd day of September, 2013, by and between Shelby County Health Care Corporation d/b/a Regional Medical Center at Memphis, a Tennessee not-for-profit corporation and acute care hospital located at 877 Jefferson Ave., Memphis, TN 38103, hereinafter ("Lessor") and Regional MED Extended Care Hospital a Tennessee limited liability company and long term acute care hospital located at 890 Madison Avenue, 4th Floor, Memphis, Tennessee, hereinafter ("Lessee").

WITNESSETH, THAT:

WHEREAS, Lessor desires to lease to Lessee and Lessee desires to lease from Lessor certain premises for the operation of a long term acute care hospital (LTACH), as subject to federal and state regulations, and the terms and conditions hereinafter set forth.

WHEREAS, Lessor leases that certain property as part of a 50 year agreement with the county, to be leased to Lessee described in Section 1.01, with room for not less than twenty- four (24) licensed patient beds and space for related support services and facilities as required for state licensure and federal certification.

WHEREAS, Lessee is engaged in the ownership, operation and management of LTACHs. For purposes of this Lease the term LTACH shall mean a hospital that meets state licensure requirements, is Medicare certified and accepts patients with chronic disorders including, but not limited to, complex medical, cardiac and respiratory conditions and those dependent upon ventilator care whose conditions are so significant that an inpatient stay of twenty-five (25) days or more is expected.

NOW THEREFORE, in consideration of the Rental Amount (as defined below) and the conditions, covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

ARTICLE 1. PREMISES, TERM, RENT, DELIVERY OF POSSESSION, AND OCCUPANCY

Section 1.01 Premises

In consideration of the rents, covenants and agreements set forth in this Lease, Lessor does hereby lease to Lessee, and Lessee does hereby lease from Lessor, 24,000 square feet of space (hereinafter the "Leased Premises") located at 890 Madison Avenue, 4th Floor, Memphis, Tennessee 38103, with parking reasonably sufficient for the needs of Lessee's employees, physicians, patients and visitors. The Leased Premises is identified further on the floor plan attached hereto as Exhibit A. Regional Medical Center at Memphis, in which the Leased Premises are located, is referred to as the "Hospital." For all purposes of this Lease, the Leased Premises shall be treated as comprising the number of square feet indicated above.

In addition to the Leased Premises, Lessee shall have use of space in common with other portions of the Hospital designated by Lessor from time to time as common areas (the "Common Areas") which include corridors, lobbies, elevators, rest rooms, parking areas, access drives, cafeteria, and medical library, Lessee's employees, patients and families shall have access to such identified space (if appropriate), subject to the terms of this Lease governing use of the Common Areas.

Lessor retains for itself, its patients, clients, guests and invitees a nonexclusive easement for ingress and egress through the hallways within the Leased Premises highlighted in yellow on Exhibit A.

Section 1.02 Term

The initial term of this Lease shall begin on the date of Lessee's receipt of Medicare certification to operate a LTACH in the State of Tennessee (the "Commencement Date.") The initial term shall be for a period of five (5) years from the Commencement Date with an option for five (5) consecutive additional five (5) year terms. This Lease shall automatically renew for the additional five (5) year term under identical terms and conditions unless either party provides written notice to the other at least one hundred eighty (180) days prior to the end of the initial term of the intent not to renew for the additional term. For purposes of this Agreement, "Term" will mean the initial five (5) year term or any additional renewal term(s) thereof.

Section 1.03 Rent

Lessee shall pay to Lessor, without demand, deduction, offset or recoupment, the monthly sum of Forty Thousand Dollars (\$40,000), payable as specified in Article 2 (the "Rental Amount"). The Rental Amount shall include general physical plant maintenance, security, parking, access to Common Areas and utilities as provided in this Lease. The Rental Amount shall also include Utilities in accordance with Section 7.01. Lessor, as part of the Rental Amount shall provide hook-up and connection of all utilities reasonably required by Lessee, including natural gas, sewage, water, telephone services, computer system services and medical gases. The monthly rental amount of Forty Thousand Dollars (\$40,000) shall be increased by one percent (1%) annually. In addition, and notwithstanding the foregoing, for each renewal Term, Lessor and Lessee may mutually agree upon increases to the Rental Amount based on current market conditions at the time.

Section 1.04 Delivery of Possession and Build-Out

Lessor shall deliver to Lessee possession of the Leased Premises on the Commencement Date. Prior to the Commencement Date, Lessee shall be permitted entry onto the Leased Premises and the Common Areas and Lessor shall provide reasonable access to the Leased Premises and Common Areas to allow Lessee to perform any approved renovations necessary to put the Leased Premises in a condition suitable for the operation of the LTACH. Lessee shall within thirty (30) days before beginning any renovation within the Leased Premises, submit to Lessor for its approval an architectural design and construction plan, approval of which shall not be unreasonably withheld. Lessee shall be responsible for all costs associated with renovating the Leased Premises to meet local, state and federal regulatory or other requirements to renovate the Leased Premises and to operate the LTACH.

If Lessor shall be unable, for any reason whatsoever, or any cause beyond the Lessor's control, to deliver possession of the Leased Premises on the Commencement Date, Lessor shall not be liable to Lessee for any damage caused thereby, nor shall this lease thereby become void or voidable, nor shall the term hereof in any way be extended, but in such event Lessee shall not be liable for any rent until such time as Lessor can and does deliver possession.

Section 1.05 Occupancy

By taking possession of the Leased Premises, Lessee accepts the Leased Premises in its then current state and stipulates its suitability for Lessee's intended purpose. Lessor shall not be required to make any improvements or repairs to the Leased Premises, except for repairs and improvements herein specifically provided and assumed by Lessor.

Section 1.06. Permitted Use and Regulatory Requirements

The Leased Premises shall be used for the purpose of operating an LTACH consisting of twenty-four (24) licensed patient beds and space for related support services and facilities as required for Licensure and Certification (both as defined below). Lessee agrees to restrict the use of the Leased Premises to such purpose, and not to use, or permit the use of, the Leased Premises for any other purpose without first obtaining the Lessor's written consent, which consent may be withheld by Lessor in the exercise of its sole discretion. Lessee shall use its best efforts to obtain and thereafter maintain in effect during the Term (i) issuance of all necessary state licenses and approvals to operate the LTACH ("Licensure"), certification as a LTACH under the Medicare program ("Certification"), and accreditation of the LTACH by The Joint Commission or such other accrediting organization as may be recognized by state and federal regulatory authorities ("Accreditation"), if applicable. Lessee shall pay all fees and costs associated with obtaining and maintaining Licensure, Certification and Accreditation, if applicable. Lessee agrees to conform to and obey all present and future laws or ordinances, all rules, regulations, requirements and orders of all governmental authorities or agencies, respecting the use of the Leased Premises, including, without limitation, all rules, regulations and requirements of the local fire department, Fire Insurance Rating Organization, or any other similar authority having jurisdiction over the Leased Premises

ARTICLE 2. PAYMENT OF RENT

Section 2.01 Advance Rental and Payment

Lessee shall, on the Commencement Date, pay to Lessor the sum of Forty Thousand Dollars (\$40,000) as payment of the Rental Amount installment for the first month of the term of this Lease. If the Commencement Date falls on a date other than the first day of the month, the Rental Amount installment due shall be prorated for the first month on the basis of the number of days during such month this Lease is in effect in relation to the total number of days in that month.

The succeeding installments of the Rental Amount shall be due on the first day of each and every succeeding month of the Term, without notice, demand, deduction, offset or recoupment, and remitted to Lessor at Regional Medical Center at Memphis, 877 Jefferson Avenue, Memphis, Tennessee 38103. Lessor may from time to time designate other places for the payment of the Rental Amount by written notice to Lessee.

Section 2.02 Late Payment of Rent

If Lessee does not pay an installment of the Rental Amount on the day when the same shall become due and payable, and such failure shall continue for a period of ten (10) days, Lessee shall pay to Lessor a service charge at the rate of one percent (1%) per month on the amount of installment(s) of the Rental Amount then in arrears. Such service charge shall be imposed for the purposes of defraying administrative expenses of Lessor and is not intended as a penalty against Lessee. The provisions of this section shall not preclude Lessor from exercising its options as set forth in any other section of this Lease or as provided by law.

ARTICLE 3. MAINTENANCE, WASTE, AND NUISANCE

Section 3.01 Maintenance and Repairs

Lessor agrees that it will keep the common areas (including heating, air conditioning, plumbing, electrical fixtures and equipment), the exterior, structural parts and roof of the Hospital and the Leased Premises and the interior of the Leased Premises in good condition and repair and that it will make such repairs as they become necessary. Lessee shall promptly notify Lessor of the necessity for any repairs or maintenance known to Lessee. The costs and expenses associated with such repairs will be paid by Lessor. Notwithstanding the foregoing, where such repairs become necessary due to the negligence of either party or its employees, agents, patients or invitees, the negligent party will be responsible for all associated costs and expenses and will fully reimburse the non-negligent party within ten (10) days of written notice of same after the completion of such repairs.

Section 3.02 Waste and Nuisance

Lessee shall not do or permit anything to be done in the Leased Premises or the Hospital that may create a nuisance or disturbance within the Leased Premises or the Hospital. Lessee shall deliver the Leased Premises at the termination of this Lease in good repair and condition. In the event Lessee should neglect reasonably to maintain the Leased Premises, Lessor shall have the right, but not the obligation, to cause repairs or corrections to be made, and any reasonable costs thereof shall be payable by Lessee to Lessor as additional rent on the next rental amount installment date.

ARTICLE 4. RIGHTS AND REMEDIES

Section 4.01 Rights and Remedies

The rights and remedies provided by this Lease are cumulative and the exercise of any one right or remedy by either party shall not preclude or waive its right to exercise any or all other remedies provided to such party by law, statute, ordinance, or otherwise.

Section 4.02 Waiver of Default

No waiver by the parties hereto of any default or breach of any term, condition, or covenant of this Lease shall be deemed to be a waiver of any other breach of the same or any other term, condition, or covenant contained herein.

Section 4.03 Attorney's Fees

In the event either party to this Lease is required to seek relief from the courts of law or equity to enforce the terms of this Lease, the prevailing party of such action shall be entitled to reasonable attorneys' fees and costs related to bringing forth such action.

Section 4.04 Excuse

Neither Lessor nor Lessee shall be required to perform any term, condition, or covenant in this Lease so long as such performance is delayed or prevented by any acts of God, strikes, lockouts, material or labor restrictions by any governmental authority, civil riot, floods, and any other cause not reasonably within the control of the Lessor or Lessee and which by the exercise of due diligence Lessor or Lessee is unable, wholly or in part, to prevent or overcome.

ARTICLE 5. ASSIGNMENT

Section 5.01 Assignment

Either party shall have the right with the prior written consent of the other party to assign this Lease, and any interest therein, including the Lessee's right to sublet the Leased Premises, or any part thereof, or any right or privilege pertinent thereto, provided that each assignee assumes in writing all of the assignor's obligations under this Lease, and the assignor shall remain liable for each and every obligation under this Lease.

Consent to assign this Lease shall not be unreasonably withheld or delayed in the event of an internal restructuring of either party.

ARTICLE 6. INDEMNITY AND INSURANCE

Section 6.01 Indemnity and Insurance

Lessee agrees to indemnify and hold Lessor and the property of Lessor, including the Leased Premises and the Hospital, free and harmless from any and all claims, liability, loss, damage, costs, expenses, and causes of action of any kind or nature asserted against Lessor, arising from or in connection with Lessee's occupation and use of the Leased Premises, or the services performed by Lessee pursuant to this Lease or from any omission or from any activity, work, or things done, permitted or suffered by Lessee in or about the Leased Premises or the Hospital. Lessee shall further indemnify, pay, defend, and hold harmless Lessor from and against any and all damages, liabilities, losses, costs, judgments, expenses, claims, and causes of action arising from any intentional or negligent act or omission of Lessee or any of Lessee's employees, agents, contractors, invitees or patients, and from and against any action or proceeding brought thereon. In case of any such action or proceeding against Lessor, Lessee, upon written notice from Lessor, shall defend the same at Lessee's sole cost and expense by counsel satisfactory to Lessor. Without limiting the generality of the foregoing, Lessee's obligations of indemnity hereunder shall extend to any hazardous material, substances, or wastes which Lessee places, utilizes, or suffers to exist on or about the Leased Premises, except to the extent Lessor has agreed to provide storage or disposal services with respect to the same, and the claims, obligations, or liabilities arise in part or in whole out of Lessor's provision (or failure to provide) such services. All of Lessee's obligations of indemnity under this Lease shall survive the termination or expiration of the Term of this Lease.

Lessee agrees to obtain the following insurance to cover Lessee's activities on the Leased Premises: property insurance covering Lessee's personal property and stock, including all of Lessor's property located on the Leased Premises, professional liability, public and general liability insurance in amounts reasonably satisfactory to Lessor, and workers' compensation. Lessee will provide certificates from the insurance companies evidencing the above required policies. Lessee shall provide Lessor with at least thirty (30) days prior written notice of cancellation of or material change to any of the policies. If Lessee shall fail to obtain any of the required insurance, or any renewal thereof, or to deliver the certificate of the same to Lessor, Lessor shall have the right, but not the obligation, without relieving Lessee of default, to obtain such insurance for the account of Lessee, and the premium and any other costs thereof shall be immediately payable to Lessor by Lessee as additional rent.

Lessor agrees to indemnify and hold Lessee free and harmless from any and all claims, liability, loss, damage, costs, expenses, and causes of action of any kind or nature asserted against Lessee, arising from or in connection with Lessor's services performed pursuant to this Lease or from any omission or from any activity, work, or things done, permitted or suffered by Lessor in or about the

Leased Premises or the Hospital. Lessor shall further indemnify, pay, defend, and hold harmless Lessee from and against any and all damages, liabilities, losses, costs, judgments, expenses, claims, and causes of action arising from any intentional or negligent act or omission of Lessor or any of Lessor's employees, agents, contractors, invitees or patients, and from and against any action or proceeding brought thereon. In case of any such action or proceeding against Lessee, Lessor, upon written notice from Lessee, shall defend the same at Lessor's sole cost and expense by counsel satisfactory to Lessee. Without limiting the generality of the foregoing, Lessor's obligations of indemnity hereunder shall extend to any hazardous material, substances, or wastes which Lessor places, utilizes, or disposes on or about the Leased Premises. All of Lessor's obligations of indemnity under this Lease shall survive the termination or expiration of the Term of this Lease. Regional Medical Center at Memphis GTLA is subject to our indemnity for any claims subject to acts are limited to amounts prescribed by the Act.

Section 6.02 Waiver of Subrogation

The parties anticipate that the fire insurance policies on the Leased Premises and on the contents therein or thereon (whether belonging to Lessor or Lessee) will contain a waiver of subrogation clause, which waiver shall read substantially as follows:

It is hereby stipulated that this insurance shall not be invalidated should the insured waive in writing prior to a loss any or all of recovery against any party for loss occurring to the property described herein or affected thereby.

Lessor and Lessee desire to obtain the benefit of the subrogation waiver and agree as follows:

- (a) Lessor and Lessee hereby waive any rights of recovery against the other for any damage to their respective properties, which are protected by their respective fire insurance policies applicable to the Leased Premises.
- (b) This Lease is not intended to and shall not in any way affect the coverage of Lessor's and Lessee's respective fire insurance policies or in any manner prejudice their rights under such insurance, and Lessor and Lessee agree that, should the waiver of subrogation clause be altered or deleted from their respective fire insurance policies or should their rights under such fire insurance policies become jeopardized by the agreement between them outlined in this Lease, then this waiver of subrogation shall

immediately become null and void without notice being required from either party to the other; and

- (c) Lessor and Lessee acknowledge that the waivers by the respective parties constitute full consideration each for the other.

ARTICLE 7. UTILITIES

Section 7.01 Utilities

Lessor shall provide hook up and connection of all utilities reasonably required by Lessee, including telephone services, computer system services, and all related equipment such as all phones and phone jacks.

Lessor shall during the Term pay all charges incurred by Lessee for telephone, and Lessor shall pay Lessee's share for gas, electricity, sewage, and water used in or on the Leased Premises and for the removal of rubbish therefrom as part of the rent as stipulated in Section 1.03.

ARTICLE 8. SIGNAGE

Section 8.01 Signage

Lessor shall provide and/or permit all reasonably necessary and appropriate signage for Lessee. Lessor shall provide and/or permit all reasonable and necessary access to and for space required for signage display. Signage includes but is not limited to outdoor signage on Leased Premises and Leased Building to notify the community of location and purpose, and indoor signage including offices, room numbers and other appropriate indicators.

Section 8.02 KEYS

Lessee agrees to promptly surrender all keys to the Leased Premises to Lessor upon the expiration or earlier termination of this Lease. Lessee further agrees to obtain return of keys to the Leased Premises from its employees upon termination of their employment.

ARTICLE 9. HAZARDOUS MATERIALS

Section 9.01 Lessee will not discharge, release, dispose of, or deposit on the Leased Premises any waste, including any pollutants, effluents, or hazardous materials ("Hazardous Materials"), in violation of any federal, state, or local law or regulation. Any Hazardous Materials generated by Lessee will be promptly

removed from the Leased Premises and disposed of in compliance with federal, state, and local laws and regulations. If at any time Lessee fails to comply with the terms of this Section, Lessor may remedy such default and Lessee must fully reimburse Lessor for any cost or expense it incurs in so acting within ten (10) days of receipt of written notice from Lessor.

ARTICLE 10. PARKING AND COMMON AREAS

Section 10.01 Parking and Common Areas

All Common Areas which shall include parking areas, driveways, entrances and exits thereto, and other facilities furnished by Lessor in or near the Leased Premises, including employee parking areas, the truck way or ways, loading docks, package pick-up stations, pedestrian sidewalks and ramps, landscaped areas, exterior stairways, elevators, waiting rooms, common lobby, restrooms and other areas and improvements provided by Lessor for the general use, in common, of Lessee and Lessor and the officers, agents, employees, patients, guests and invitees of either of them, shall at all times be subject to the exclusive control and management of Lessor.

Lessor shall have the right to construct, maintain and operate lighting facilities and improvements on all Common Areas; to police the same; from time to time to change the area, level, location and arrangement of parking areas and other Common Areas referred to above; to close temporarily all or any portion of the parking areas or other Common Areas; and to do and perform such other acts and make such other improvements in and to the Common Areas as Lessor shall determine to be advisable. Lessor will operate and maintain the Common Areas in such manner as Lessor, in its sole discretion, shall determine from time to time. Without limiting the scope of such discretion, Lessor shall have the full right and authority to employ all personnel and to make all rules and regulations pertaining to and necessary for the proper operation and maintenance of the Common Areas.

ARTICLE 11. ALTERATIONS, IMPROVEMENTS, AND FIXTURES

Section 11.01 Alterations, Improvements, and Fixtures

Except as otherwise provided in this Lease, Lessee shall not, without the prior written consent of Lessor to do so, alter or improve the Leased Premises, attach any fixtures in or to the Leased Premises, permit any annoying sound device, install any additional locks, overload any floor, or deface the Leased Premises. Any and all alterations, additions, and fixtures (except trade fixtures, which Lessee shall be permitted to remove from the Leased Premises at any time during the Term hereof if Lessee is not in default under this Lease and such

removal can be effected without injury to the Leased Premises) made or placed in or on the Leased Premises by Lessee shall on expiration, or earlier termination of this Lease, belong to Lessor without compensation to Lessee. Notwithstanding the foregoing, Lessor shall have the option to be exercised on expiration or earlier termination of this Lease, to require Lessee to remove any or all of such additions, improvements, or fixtures and to restore the Leased Premises, at Lessee's expense, to its original condition, ordinary wear and tear from reasonable use excepted. Before installing any fixtures in or on the Leased Premises, Lessee shall submit plans and designs therefor to Lessor for its approval, and in the event that the plans and designs are disapproved by Lessor, such fixtures shall not be installed until any changes required by Lessor are made.

Section 11.02 Inspection by Lessor

Lessee shall permit Lessor and its agents to enter into and upon the Leased Premises at all reasonable times and without abatement of the Rental Amount for the purpose of inspecting the Leased Premises or for the purpose of maintaining or making repairs or alterations to the Hospital. Lessee further agrees that during the six (6) months preceding the end of the Term, Lessor may show the Leased Premises to persons wishing to rent it, provided Lessor gives Lessee reasonable prior notice of any showings and such showings are carried out so as not to unreasonably interfere with the use of the Leased Premises by Lessee in the operation of the LTACH.

Section 11.03 Destruction of or Damage to the Leased Premises

If during the term of this lease, the Leased Premises or the Hospital is, because of fire, the elements, Act of God, or any cause not brought about by the negligence of Lessor, either destroyed or partially destroyed so as to render the Leased Premises wholly unfit for occupancy and if in the judgment of Lessor the damage resulting cannot be repaired within sixty (60) days from such damage, or if the Hospital or any part thereof is so injured or destroyed that Lessor shall decide to demolish, rebuild, or reconstruct the Hospital or any part thereof, this Lease shall, at the option of either party, terminate from the date of such damage destruction, or decision, and Lessee shall immediately surrender the Leased Premises to Lessor, and in such event Lessee shall continue to owe and pay installments of the Rental Amount up to, but not beyond, the time of such surrender. If the Leased Premises shall be injured or damaged by fire, the elements, Acts of God, or any cause not brought about by the negligence of Lessor, but not rendered untenable and Lessor shall determine not to demolish, rebuild or reconstruct as above, Lessor shall repair such damage within a reasonable time after written notice to it of such damage. Installments of the Rental Amount shall be equitably abated during such period to account for any days Lessee is unable to utilize the Leased Premises.

Section 11.04 Eminent Domain

If more than twenty-five percent (25%) of the occupiable area of the Leased Premises shall be conveyed to or taken by any authorized entity under threat of or by eminent domain, this Lease shall terminate as of the date when possession thereof is surrendered by Lessee and all rights of Lessee in this Lease shall immediately cease and terminate. If twenty-five percent (25%) or less of the occupiable area of the Leased Premises shall be so conveyed or taken, the Rental Amount for the Premises shall be proportionately abated or either party may elect to terminate this Lease by giving the other party thirty (30) days' written notice of such election.

Section 11.05 Liability of Lessor

Lessor does not warrant that any services to be provided by Lessor will be free from interruption due to causes beyond Lessor's reasonable control. The temporary interruption of services or delay in the making of repairs will not be deemed an eviction nor disturbance of Lessee's use and possession of the Leased Premises nor render Lessor liable to Lessee for damage by set-off or abatement of the Rental Amount or otherwise, nor will it relieve Lessee from performance of Lessee's obligations under this Lease. Furthermore, Lessor shall not be liable to Lessee for damage to person or property caused by defects in the cooling, heating, electric, water, natural gas, elevator or other apparatus or systems or by water or natural gas discharged from systems, including sprinkler systems, if any, in the Hospital, nor for the theft, mysterious disappearance, or loss of any property of Lessee whether from the Leased Premises, or any part of the Hospital or property adjoining the Hospital. Lessor agrees to make reasonable efforts to protect Lessee from interference or disturbance by third persons including other tenants of the Hospital; however Lessor shall not be liable for any such interference or disturbance whether caused by another tenant or tenants of Lessor or other person, nor shall Lessee be relieved from any obligation herein because of such interference, disturbance or breach.

Section 11.06 Subordination

This Lease is and shall be subordinate to any encumbrance or mortgage now or hereafter affecting title to the real property on which the Hospital is situated. Lessee agrees upon Lessor's request from time to time to execute any paper or papers prepared, at Lessor's expense, which Lessor or any mortgagee, mortgagor, or subsequent purchaser may deem necessary to subject and subordinate this Lease to the lien of any mortgage or other encumbrance now or hereafter affecting title to the real property on which the Hospital is situated. At every request of the holder or holders of such mortgages or notes, Lessee agrees to promptly execute lease ratification agreements showing that this Lease is in full force and effect, that the Lessee is then in possession of the Leased Premises and paying the full Rental Amount, that no installments of the Rental

Amounts have been made in advance except as therein stated, and stating the Commencement Date. The failure of Lessee to execute any such instruments, releases, or documents will constitute a default under this Lease. In case of the failure of Lessee to execute said instruments on demand, Lessor is authorized, as the attorney and agent of Lessee, to execute such releases, instruments, or other documents, and in such event, Lessee confirms and ratifies any instruments executed by virtue of this power of attorney

ARTICLE 12. QUIET POSSESSION

Section 12.01 Quiet Possession

Lessee shall, on the Commencement Date of the Term of this Lease, will peacefully and quietly hold, occupy and enjoy the Leased Premises during the Term without any hindrance or molestation by Lessor or any persons lawfully claiming under Lessor, subject, however, to the provisions of this Lease.

Section 12.02 Covenant Regarding Encumbrances

Lessor covenants that the Leased Premises are not subject to any lien, claim, or encumbrance, except as hereinafter set forth, and that it is not in default or arrears in the making of any payment or performance of any obligation relating to the Leases Premises.

ARTICLE 13. ELEVATORS

Section 13.01 Elevators

Lessor shall provide access to and use of necessary elevator facilities to Lessee, its officers, agents, employees, patients, and visitors. Lessor shall keep in good repair and working order all elevators utilized by Lessee, its officers, agents, employees, patients and visitors.

ARTICLE 14. DEFAULT

Section 14.01 Default

Failure of Lessee to pay any installment of the Rental Amount or other sums due and owing under this Lease, as and when the same becomes due and payable, or the failure of Lessee to promptly and faithfully to keep and perform each and every covenant, agreement and stipulation in this Lease on the part of Lessee to

be kept and performed, shall, at the option of Lessor, constitute a default by Lessee under this Lease.

In the event that Lessee breaches this Lease, then Lessor shall provide written notice demanding cure of such breach. Such notice shall indicate the specific term or terms of this Lease which have been breached and describe, in reasonable detail, the event or events that have caused the breach. If the event causing such notice is the bankruptcy, or appointment of a receiver for the Lessee, then this Lease shall terminate forthwith, unless it is with respect to an involuntary proceeding in which case this Lease shall terminate if such proceeding is not dismissed within ninety (90) days. If the event causing such notice is other than bankruptcy or insolvency, Lessee shall have a period of thirty (30) days following receipt of such notice to cure the breach. If Lessee defaults in the payment of any installment of the Rental Amount, Additional Rent or other sums due and owing under this Lease, Lessee shall have a period of ten (10) days following receipt of written notice from Lessor to cure such payment default. If Lessee fails to correct or remedy the breach within such period, then Lessor may terminate this Lease immediately upon delivery of written notice to Lessee.

In the case of any breach or default of this Lease by Lessee, Lessor shall have all of the remedies, rights, and authority against and with respect to Lessee provided by law. If Lessee fails to perform any obligation under this Lease for the period provided above after written notice by Lessor (except that no notice is required in emergencies), Lessor will have the right (but not the duty) to perform the obligation on behalf and for the account of Lessee. In this event, Lessee must reimburse Lessor upon demand, as additional rent, for all expenses incurred by Lessor in performing Lessee's obligation.

Section 14.02 Effect of Governmental Regulations and Lessee Dissolution

Notwithstanding any other provisions of this Lease, this Lease may be terminated upon thirty (30) days' notice by Lessee in the event that legislative or administrative statutes, rules, regulations or other mandates which relate to reimbursement rates or the ability to receive reimbursement under the Medicare Prospective Payment System for Long Term Care Hospitals are enacted, imposed or revised such that the continued financial viability of Lessee is materially compromised.

Notwithstanding any other provision in this Lease, this Lease shall automatically terminate on the dissolution of the Lessee for any reason whatsoever.

Section 14.03 Removal of Lessee's Personal Property

If Lessee is not in default under this Lease, Lessee shall have the right at any time within thirty (30) days prior to the date of termination of this Lease, to

remove from the Leased Premises all personal property owned by Lessee, provided that Lessee shall surrender the Leased Premises to Lessor, as the Premises were upon the date of delivery to Lessee, ordinary wear and tear from reasonable use excepted. Lessee shall be responsible for any damage caused by the removal of Lessee's personal property.

ARTICLE 15. MISCELLANEOUS

Section 15.01 Notices and Addresses

All notices provided to be given under this Lease shall be given by certified mail or registered mail, addressed to the proper party or their registered agents, at the following addresses:

Lessor: Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

Attn: Bret Perisho, Vice President
Strategic Business Development

CC: Monica Wharton, Senior Vice President
Chief Legal Officer and General Counsel

Lessee: Regional Med Extended Care Hospital
890 Madison Avenue, 4th Floor
Memphis, TN 38103

Attn: Administrator

Section 15.02 Parties Bound

This Lease shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, executors, administrators, legal representatives, successors, and assigns when permitted by this Lease.

Section 15.03 Applicable Law

This agreement shall be construed under and in accordance with the laws of the State of Tennessee. Venue shall be in court of competent jurisdiction that is located in or in proximity to Shelby County, Tennessee.

Section 15.04 Reporting Requirements and Patient Records

The parties agree that if this Lease is subject to the Medicare status and regulations governing access to books and records of subcontractors, each party shall retain and, for five (5) years after services are furnished hereunder, shall allow the authorized representatives of the other, the Comptroller General, the Tennessee Department of Health, and the Centers for Medicare and Medicaid Services (CMS) access to this Lease and to such books, records, and other documents that are necessary to verify the nature and extent of the costs of services. In the event either party receives a request for access, it agrees to notify the other immediately and to consult with the other party regarding what response will be made to the request. If either party carries out any responsibilities under this Lease through the use of a subcontractor, including any organization related by ownership or control, the party so contracting, if so required by any applicable laws or regulations shall obtain and forward to the other the subcontractor's written promise to be bound under this same Lease.

All medical charts and records of the patients and patient care with respect to patients for whom Lessee provides services under this Lease shall be the property of Lessee and, except as otherwise provided in this Lease, shall be kept by Lessee upon termination or expiration of this Lease. In the event that Lessee is in default and this Lease terminates pursuant to the terms of this Lease, Lessee shall cooperate with Lessor in transferring patient records for any patients which may be then housed in the Hospital in accordance with all applicable health care statutes, laws, rules, regulations and good and sound medical practice and Lessee shall, at all times, comply with such rules regarding transfer of ownership and/or operation in all respects.

Section 15.05 Renegotiation / Termination Due to Illegal Provision

In the event that CMS finds any provision of this Lease to be in contravention of any Federal regulation or law, Lessor and Lessee shall meet in good faith to promptly renegotiate this Lease to conform to Federal regulation or law. If such change is not acceptable to the other party to this Lease, notwithstanding any other provision of this Lease, either party shall be entitled to immediately terminate this Lease.

Section 15.06 Other Government Requirements

This Lease may be terminated upon thirty (30) days written notice by either party to the other should the federal or state government enact any new laws or regulations, reinterpret existing laws or regulations, that would substantially impair the operations of the Lessee's long term care hospital, or change the payment methodologies for long term care hospitals or should the Lessee not obtain or lose any required state license or Medicare certification to operate the long term care hospital.

Neither Lessor nor Lessee will have any obligation to refer any patients of either of them or any other person to Lessor or Lessee for the provision of any service or item of any kind. Lessor and Lessee acknowledge that the Leased Premises does not exceed the space which is reasonable and necessary for Lessee's operations as described in this Lease. All of the sums paid pursuant to this Lease are paid as rentals only, are set in advance, are consistent with fair market value (without regard to proximity to referral sources), do not exceed those rentals that are reasonable as determined in arms-length commercial transactions, are not determined in a manner that takes into account in any way any volume or value of referrals or business generated between the parties, are intended to fall within the applicable Federal anti-kickback safe harbor (42 C.F.R. §1001.952(b)), and are to be construed and applied in accordance with this paramount intent.

Section 15.07 Contingencies

The rights and obligations of Lessor and Lessee under this Lease are contingent upon the Lessee receiving any necessary approval from all appropriate Tennessee agencies permitting the licensure and operation of the LTACH on the Leased Premises, and is also contingent upon receipt of any necessary approvals and certifications from CMS permitting Medicare participation as an LTACH on the Leased Premises.

Lessee shall maintain in good standing, all of its federal, state and local licenses and certificates required by law and as a Medicare provider throughout the Term.

Section 15.08 Legal Construction

In case any one or more of the provisions contained in this Lease shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision hereof and this Lease shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

Section 15.09 Amendment

No amendment, modification, or alteration of the terms hereof shall be binding unless the same is put in writing, dated subsequent to the date hereof, and duly executed by the parties hereto.

Section 15.10 Time

Time is of the essence with respect to all provisions of this Lease.

Section 15.11 Enforceability

If any covenant or provision of this Lease is held to be invalid or unenforceable by a court of competent jurisdiction, such holding shall not affect the validity of the remaining covenants and provisions, it being the intention of the parties that this Lease be so construed as to render enforceable that portion of this Lease unaffected by such holding. The contractual provisions shall be deemed severable.

Section 15.12 Counterparts

This Lease may be executed in any number of counterparts, each of which shall be an original, but all of which together shall constitute one and the same instrument.

Section 15.13 Waiver

Failure by either party to enforce any of the provisions hereof for any length of time shall not be deemed a waiver of its rights set forth in this Lease. Such a waiver may be made only by an instrument in writing signed by the party sought to be charged with the waiver.

Section 15.14 Memorandum of Lease

Lessee agrees that it will not record this Lease. Both parties will, upon the request of either, execute and deliver a notice or memorandum of this Lease in the form permitted by statute and satisfactory for recording. If this Lease is terminated before the Term expires, the parties will execute and record an instrument acknowledging that fact and the actual date of termination of this Lease.

IN WITNESS WHEREOF, the undersigned Lessor and Lessee hereto execute this agreement as of the day and year first written above.

LESSOR: Shelby County Health Care Corporation

BY: 

TITLE: President/CEO

LESSEE: Regional MED Extended Care Hospital

BY: 

TITLE: CEO/Administrator

Notarization on Next Page

STATE OF TENNESSEE
COUNTY OF SHELBY

The foregoing instrument was acknowledged before me this day of 22nd
November, 2013 by Dr. Reginald Coopwood, (title)
President/CEO
of Shelby County Health Care Corporation, a Tennessee nonprofit corporation,
on its behalf



Emily Neyman
NOTARY PUBLIC

Print Name: Emily Neyman

My Comm. Expires: 3-1-17

My Commission Expires:
March 1, 2017

STATE OF TENNESSEE
COUNTY OF SHELBY

The foregoing instrument was acknowledged before me this day of 22nd
November, 2013, by Mark Kelly, (title)
CEO/Administrator of
Regional MED Extended care Hospital, a Tennessee limited liability company
on its behalf



Emily Neyman
NOTARY PUBLIC

Print Name: Emily Neyman

My Comm. Expires: 3-1-17

My Commission Expires:
March 1, 2017

EXHIBIT A

Description of the Premises

OPTION TO LEASE

For and in consideration of \$1.00, cash in hand paid, the receipt of which is hereby acknowledged, and other good and valuable consideration, Shelby County Health Care Corporation, d/b/a Regional One Health ("ROH") hereby bargains, sells and grants to Regional MED Extended Care Hospital, LLC ("The LTACH"), its successors and assigns, the right and option to amend the current Lease Agreement between the parties dated September 23, 2013 (the "Lease"), to add an additional 6 beds and support space located on the second floor (2nd) floor of Turner Tower on the campus of ROH (the "Premises") to expand the LTACH's operation of a long term acute care hospital from twenty-four (24) beds to thirty (30) beds. The terms and conditions of the amendment to the Lease to be executed by and between the parties (the "Amendment") shall be in accordance with the terms and conditions set forth in this option and the Lease. If there is any conflict between the provisions of this Option to Lease and the Amendment, the provisions of the Amendment shall prevail. The LTACH must provide notice to ROH of its intention to exercise this Option, as provided below.

It is anticipated that the Amendment, when executed, shall be co-terminus with the Lease at an additional cost to The LTACH of One Hundred Twenty-Five Thousand Dollars (\$125,000) per year, and such Amendment shall be executed not later than sixty (60) days after The LTACH receives approval of a Certificate of Need from the Tennessee Health Services and Development Agency for its hospital to be expanded in the Premises. If The LTACH does not file a Certificate of Need within ninety (90) days of execution of this Option to Lease, this Option to Lease shall terminate and be of no further force and effect. If The LTACH's Certificate of Need application is petitioned for a Contested Case Hearing, this Option to Lease shall continue in effect until ten (10) days following any favorable decision on the Contested Case Hearing. If the parties fail to reach agreement as to the terms and conditions of the Amendment within thirty (30) days after The LTACH gives notice of its intent to exercise its Option to Lease, then this Option shall terminate and be of no further force and effect.

The provisions of this Option shall be binding upon and inure to the benefit of both parties and their respective heirs, successors and assigns.

This Option shall be construed in accordance with and governed by the laws of the State of Tennessee. Time is expressly declared to be of the essence of this Option.

IN WITNESS WHEREOF, the parties have signed this option on this 11 day of August, 2017.

SHELBY COUNTY HEALTH CARE CORPORATION

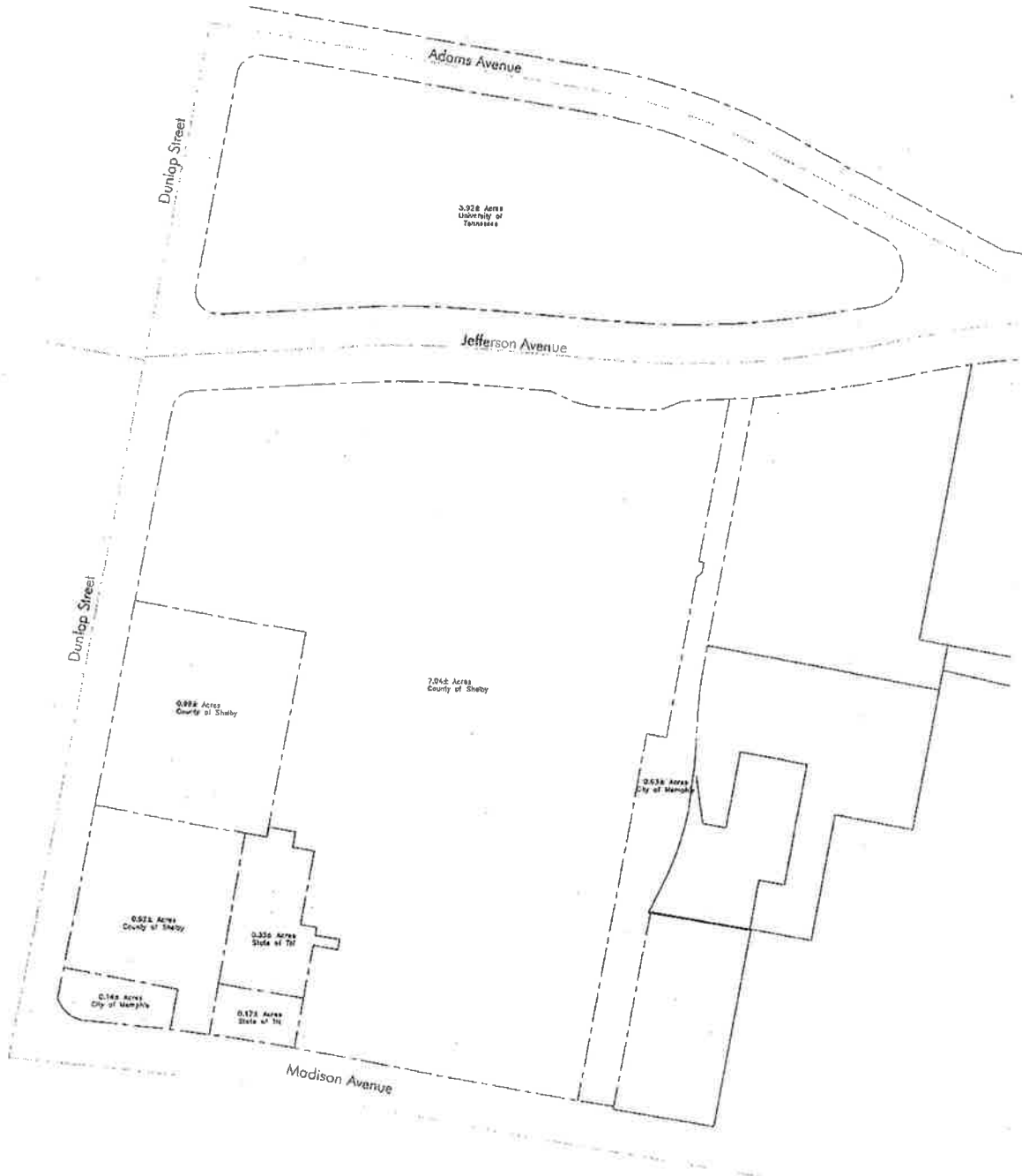
BY: _____

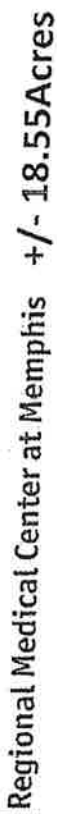
J. Richard Wagers, Sr. EVP/CFO

Regional MED Extended Care Hospital, LLC

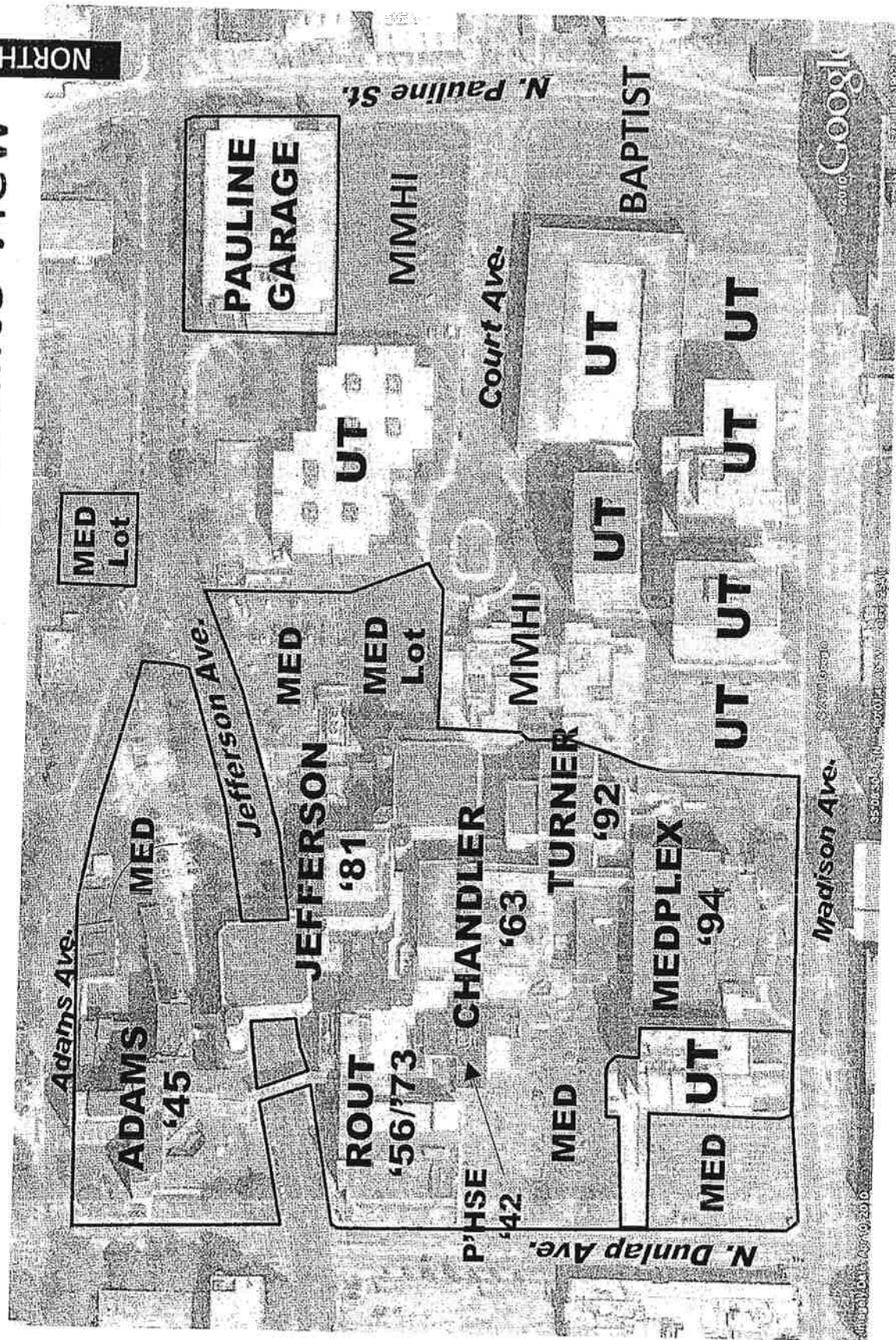
BY: _____

Mark A. Kelly, CEO/Administrator





Satellite View



APM
Architectural Planning Method

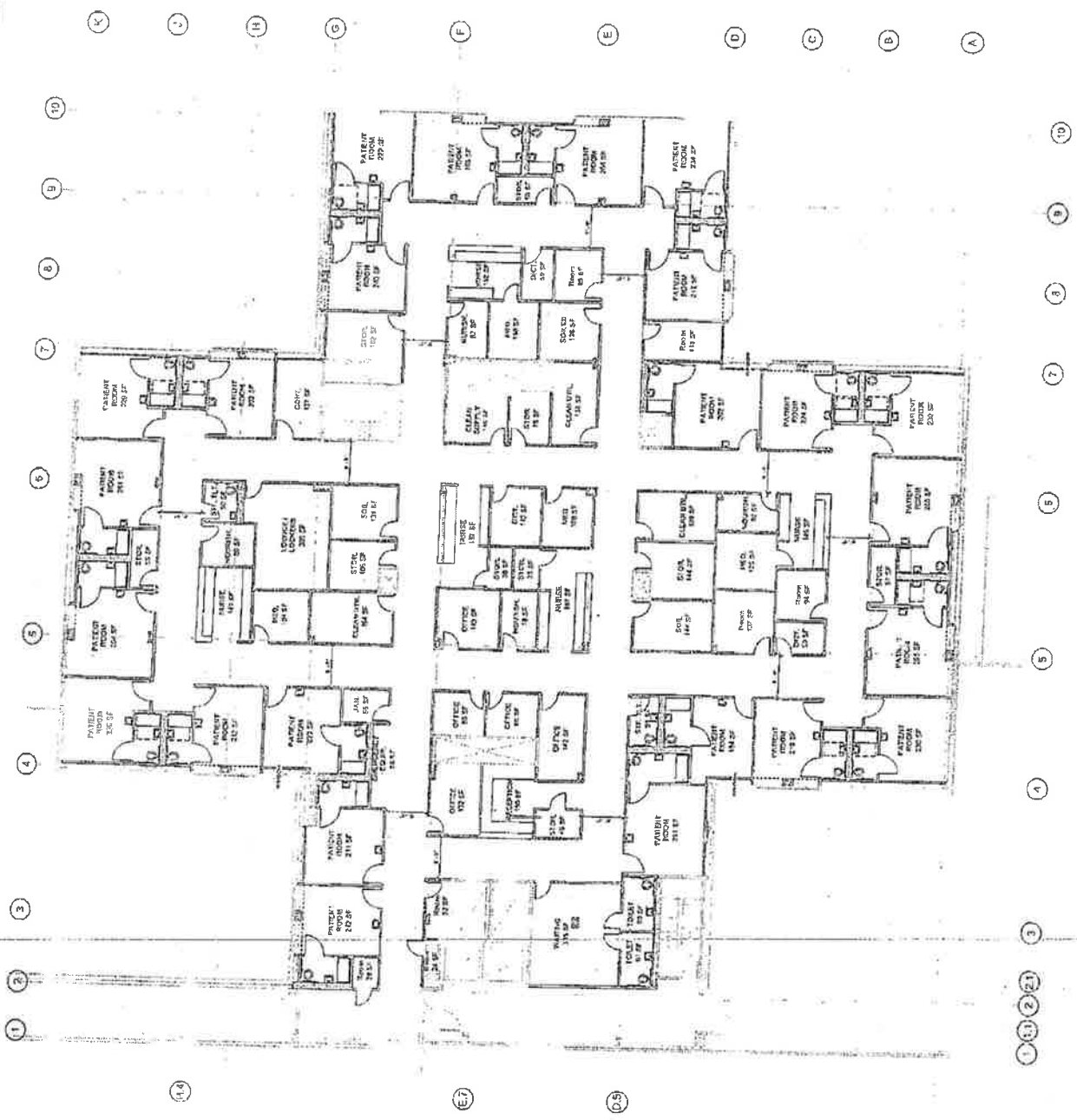
WALL TYPE LEGEND

KEY PLAN

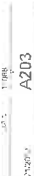
Attachment A.6.B.2

**REGIONAL MEDICAL CENTER
ATTACHMENT
TURNER TOWER RENOVATION**

4TH FLOOR PLAN
TURNER TOWER



1. 4TH FLOOR PLAN - MED SURG - TURNER TOWER



- B.** Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services.

Response: Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) and listed in that order are indicated in the chart below. These numbers are taken off the most recent JARs available (2015).

The Applicant (Regional MED) lists data for 2017, our most recent data. It is important to note that the Applicant has been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor would result in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity (the reported 84.2% occupancy rate is based on licensed beds). The addition of these six (6) beds will allow us to more fully provide LTACH services to patients in need of such services by helping us increase the number of beds being staffed, which will result in a more cost-efficient manner in which to provide the care. Please see chart below:

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	\$6,987.64	\$5,283.73	\$1,703.91
Methodist	36	31.46	87.4%	\$4,023.54	\$2,661.94	\$1,361.60
Select Specialty	39	36.66	94.0%	\$10,507.78	\$7,388.76	\$3,119.02
Regional MED	24	20.21	84.2%	\$8,499.58	\$6,683.20	\$1,816.38
Total	129	111.22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day

Adj. = Contractual Adjustments per Patient Day

Net = Net Operating Revenue per Patient Day

Further, the requested increase will have no impact on existing LTACH providers. If anything, it will help those providers by our having more beds for referrals from existing hospitals in Memphis. The Applicant provides inpatient long term acute care hospital (LTACH) services to an area that has recently lost many LTACH beds. Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency. This means sixty (60) existing and/or approved LTACH beds will not be available to serve patients who need those services. This application, to add six (6) LTACH beds, is a small step in alleviating that problem, and will improve the health of the people of Tennessee who require such services. Due to all of those beds being turned in, the addition of the few beds we request will have little impact on existing providers in the area.

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

The above guideline was utilized. The Applicant used the "Formula for 0.5 Long Term Care Beds per 10,000 Population by County" chart supplied by the Tennessee Department of Health, Office of Healthcare Facility Statistics.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

The Applicant operated at 84.2% in 2017 based on licensed beds, and 96.3% based on staffed beds.

3. The population shall be the current year's population, projected two years forward.

The above guideline was utilized. The Applicant used the "Formula for 0.5 Long Term Care Beds per 10,000 Population by County" chart supplied by the Tennessee Department of Health, Office of Healthcare Facility Statistics.

4. The primary service area can not be smaller than the applicant's Community Service Area (CSA). If LTH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

As the service being provided is very specialized, patients originate from a wide geographic area. The facility's existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant.

5. Long-term care hospitals should have a minimum size of 20 beds.

The Applicant is currently licensed for 24 beds.

[Type here]

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

LTACHs are a function of CMS. Prior to the creation of LTACHs, hospitals had to care for chronically ill patients – those requiring weeks and perhaps months of hospital stays. Based on traditional hospital reimbursement, acute care facilities lost tremendous amounts of funds caring for such individuals. This fact was recognized, and a special category of patients (long term acute care hospital patients) and resultant beds were established that received more appropriate reimbursement. This project continues that additional benefit to the patients they serve, all at a substantial savings over more traditional acute care.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

This guideline is already being met, and will continue to be met.

3. Provisions will be made so that a minimum of 5% of the patient population using long term acute care beds will be charity or indigent care.

Fortunately, CMS recognizes the unique nature of these patients and provides LTACH facilities with substantial reimbursement to help cover the substantial costs incurred by the facilities. In effect, CMS tries to reimburse LTACH facilities in order to keep them in business. To that extent, most patients will qualify for some type of reimbursement. The Applicant recognizes that some patients may need charitable care, and provisions are made for such patients.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long-term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

[Type here]

The above guideline is met. The Applicant is a licensed LTACH, and provides appropriate long term acute care services to the patients it serves.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

The above guideline has been met, historically, and will continue to be met.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

The above guideline has been met, historically, and will continue to be met.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

The above guideline has been met, historically, and will continue to be met. The Applicant is located inside a tertiary facility.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should be conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

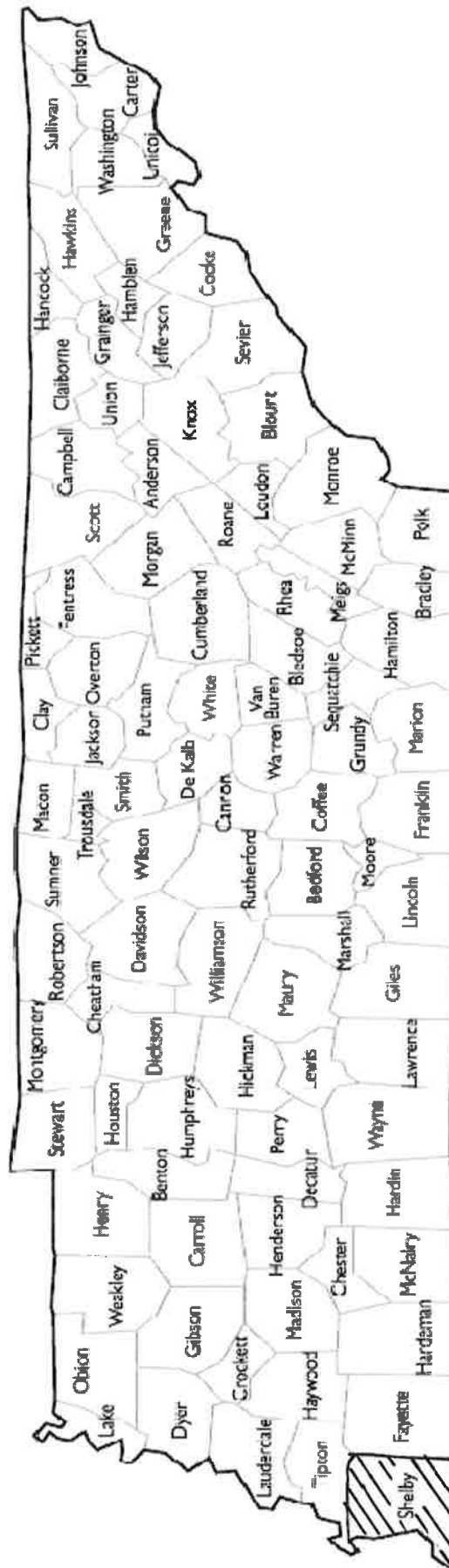
The Applicant accepts this condition.

[Type here]

Patient Origin:

Shelby County	95
Other TN Counties	19
Mississippi	38
Arkansas	27
Missouri	1
Alabama	1

Total	181
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QuickFacts

selected: **Shelby County, Tennessee; UNITED STATES**

QuickFacts provides statistics for all states and counties, and for cities and towns with a *population of 5,000 or more*.

Table

All Topics	Shelby County, Tennessee	UNITED STATES
Population per square mile, 2010	1,215.5	87.4
 PEOPLE		
Population		
Population estimates, July 1, 2016, (V2016)	934,603	323,127,513
Population estimates base, April 1, 2010, (V2016)	927,684	308,758,105
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	0.7%	4.7%
Population, Census, April 1, 2010	927,644	308,745,538
Age and Sex		
Persons under 5 years, percent, July 1, 2016, (V2016)	7.2%	6.2%
Persons under 5 years, percent, April 1, 2010	7.2%	6.5%
Persons under 18 years, percent, July 1, 2016, (V2016)	25.2%	22.8%
Persons under 18 years, percent, April 1, 2010	26.4%	24.0%
Persons 65 years and over, percent, July 1, 2016, (V2016)	12.5%	15.2%
Persons 65 years and over, percent, April 1, 2010	10.3%	13.0%
Female persons, percent, July 1, 2016, (V2016)	52.4%	50.8%
Female persons, percent, April 1, 2010	52.3%	50.8%
Race and Hispanic Origin		
White alone, percent, July 1, 2016, (V2016) (a)	41.4%	76.9%
White alone, percent, April 1, 2010 (a)	40.6%	72.4%
Black or African American alone, percent, July 1, 2016, (V2016) (a)	54.1%	13.3%
Black or African American alone, percent, April 1, 2010 (a)	52.1%	12.6%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016) (a)	0.4%	1.3%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.2%	0.9%
Asian alone, percent, July 1, 2016, (V2016) (a)	2.6%	5.7%
Asian alone, percent, April 1, 2010 (a)	2.3%	4.8%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016) (a)	0.1%	0.2%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.2%
Two or More Races, percent, July 1, 2016, (V2016)	1.5%	2.6%
Two or More Races, percent, April 1, 2010	1.4%	2.9%
Hispanic or Latino, percent, July 1, 2016, (V2016) (b)	6.1%	17.8%
Hispanic or Latino, percent, April 1, 2010 (b)	5.6%	16.3%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	36.2%	61.3%
White alone, not Hispanic or Latino, percent, April 1, 2010	38.7%	63.7%
Population Characteristics		
Veterans, 2011-2015	54,847	20,108,332
Foreign born persons, percent, 2011-2015	6.2%	13.2%
Housing		
Housing units, July 1, 2016, (V2016)	406,022	135,697,926
Housing units, April 1, 2010	398,274	131,704,730
Owner-occupied housing unit rate, 2011-2015	57.3%	63.9%
Median value of owner-occupied housing units, 2011-2015	\$130,800	\$178,600
Median selected monthly owner costs -with a mortgage, 2011-2015	\$1,352	\$1,492
Median selected monthly owner costs -without a mortgage, 2011-2015	\$479	\$458
Median gross rent, 2011-2015	\$859	\$928
Building permits, 2016	2,338	1,206,642
Families & Living Arrangements		
Households, 2011-2015	347,224	116,926,305
Persons per household, 2011-2015	2.65	2.64
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	83.1%	85.1%

Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	9.4%	21.0%
Education		
High school graduate or higher, percent of persons age 25 years+, 2011-2015	86.9%	86.7%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	30.2%	29.8%
Health		
With a disability, under age 65 years, percent, 2011-2015	9.3%	8.6%
Persons without health insurance, under age 65 years, percent	▲ 13.6%	▲ 10.5%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2011-2015	65.4%	63.3%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	62.0%	58.5%
Total accommodation and food services sales, 2012 (\$1,000) (c)	1,889,742	708,138,598
Total health care and social assistance receipts/revenue, 2012 (\$1,000) (c)	8,166,690	2,040,441,203
Total manufacturers shipments, 2012 (\$1,000) (c)	22,412,702	5,696,729,632
Total merchant wholesaler sales, 2012 (\$1,000) (c)	35,454,262	5,208,023,478
Total retail sales, 2012 (\$1,000) (c)	22,058,481	4,219,821,871
Total retail sales per capita, 2012 (c)	\$23,447	\$13,443
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	22.6	25.9
Income & Poverty		
Median household income (in 2015 dollars), 2011-2015	\$46,224	\$53,889
Per capita income in past 12 months (in 2015 dollars), 2011-2015	\$26,285	\$28,930
Persons in poverty, percent	▲ 20.2%	▲ 13.5%



BUSINESSES

Businesses

Total employer establishments, 2015	19,311	7,663,938
Total employment, 2015	430,779	124,085,947
Total annual payroll, 2015 (\$1,000)	21,121,882	6,253,488,252
Total employment, percent change, 2014-2015	1.0%	2.5%
Total nonemployer establishments, 2015	78,921	24,331,403
All firms, 2012	95,433	27,626,360
Men-owned firms, 2012	43,633	14,844,597
Women-owned firms, 2012	45,031	9,878,397
Minority-owned firms, 2012	52,295	7,952,386
Nonminority-owned firms, 2012	40,569	18,987,918
Veteran-owned firms, 2012	9,486	2,521,682
Nonveteran-owned firms, 2012	82,645	24,070,685




GEOGRAPHY

Geography

Population per square mile, 2010	1,215.5	87.4
Land area in square miles, 2010	763.17	3,531,905.43
FIPS Code	47157	00

Value Notes

 This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Int left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2016) refers to the final year of the series (2010 thru 2016). *Different vintage years of estimates are not comparable.*

Fact Notes

- (a) Includes persons reporting only one race
- (b) Hispanics may be of any race, so also are included in applicable race categories
- (c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- D Suppressed to avoid disclosure of confidential information
- F Fewer than 25 firms
- FN Footnote on this item in place of data
- NA Not available
- S Suppressed; does not meet publication standards
- X Not applicable
- Z Value greater than zero but less than half unit of measure shown
- Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the low interval of an open ended distribution.

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area SHealth Insurance Estimates, Small Area Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.


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MUA Find Results

Search Criteria

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Data as of 8/10/2017

State: Tennessee

County: Shelby County

MUA ID: All

[Collapse All](#)


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04 items in 01 pa

County Name ①	County FIPS Code ①	Service Area Name ①	MUA/P Source Identification Number ①	Designation Type ①	Population Type ①	Index of Medical Underservice Score ①	MUA/P Designation Date ①	MUA/P Update Date ①
Shelby County	157	Shelby Service Area	03249	Medically Underserved Area	Medically Underserved Area	56.50	07/12/1994	07/12/1994
CT 0201.01 CT 0201.02 CT 0202.10 CT 0205.12								
Shelby County	157	Shelby Service Area	03250	Medically Underserved Area	Medically Underserved Area	51.00	07/12/1994	07/12/1994
CT 0216.20 CT 0219.00 CT 0220.22 CT 0220.23 CT 0220.24 CT 0221.11 CT 0221.12 CT 0222.10 CT 0222.20 CT 0223.10 CT 0223.21 CT 0223.30 CT 0224.10 CT 0225.00 CT 0227.00								
Shelby County	157	Nw Memphis Service Area	07469	Medically Underserved Area	Medically Underserved Area	56.00	04/06/2005	04/06/2005

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<u>County Name</u> ⓘ	<u>County FIPS Code</u> ⓘ	<u>Service Area Name</u> ⓘ	<u>MUA/P Source Identification Number</u> ⓘ	<u>Designation Type</u> ⓘ	<u>Population Type</u> ⓘ	<u>Index of Medical Underservice Score</u> ⓘ	<u>MUA/P Designation Date</u> ⓘ	<u>MUA/P Update Date</u> ⓘ
CT 0002.00								
CT 0003.00								
CT 0004.00								
CT 0006.00								
CT 0007.00								
CT 0008.00								
CT 0009.00								
CT 0011.00								
CT 0012.00								
CT 0013.00								
CT 0014.00								
CT 0015.00								
CT 0017.00								
CT 0019.00								
CT 0020.00								
CT 0021.00								
CT 0024.00								
CT 0025.00								
CT 0027.00								
CT 0028.00								
CT 0030.00								
CT 0036.00								
CT 0069.00								
CT 0099.01								
CT 0099.02								
CT 0100.00								
CT 0101.10								
CT 0101.20								
CT 0102.10								
CT 0102.20								
CT 0103.00								
CT 0111.00								
CT 0112.00								
CT 0113.00								
CT 0205.21								
CT 0205.23								
CT 0205.24								
Shelby County	157	Southeast Memphi	07971	Medically Underserved Area	Medically Underserved Area	58.10	07/31/2014	07/31/2014

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County Name ⓘ	County FIPS Code ⓘ	Service Area Name ⓘ	MUA/P Source Identification Number ⓘ	Designation Type ⓘ	Population Type ⓘ	Index of Medical Underservice Score ⓘ	MUA/P Designation Date ⓘ	MUA/P Update Da ⓘ	
<div>CT 0081.10</div> <div>CT 0081.20</div> <div>CT 0082.00</div> <div>CT 0097.00</div> <div>CT 0105.00</div> <div>CT 0106.10</div> <div>CT 0106.20</div> <div>CT 0106.30</div> <div>CT 0107.10</div> <div>CT 0107.20</div> <div>CT 0108.10</div> <div>CT 0108.20</div> <div>CT 0110.10</div> <div>CT 0110.20</div> <div>CT 0118.00</div> <div>CT 0217.10</div> <div>CT 0217.21</div> <div>CT 0217.24</div> <div>CT 0217.25</div> <div>CT 0217.26</div> <div>CT 0217.31</div> <div>CT 0217.32</div> <div>CT 0217.41</div> <div>CT 0217.44</div> <div>CT 0217.45</div> <div>CT 0217.46</div> <div>CT 0217.47</div> <div>CT 0217.51</div> <div>CT 0217.52</div> <div>CT 0217.53</div> <div>CT 0217.54</div> <div>CT 0226.00</div> <div>CT 9801.00</div>									
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HRSA Data Warehouse

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HPSA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

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Map View

Data as of 8/10/2017

State: Tennessee

County: Shelby County

Discipline: Primary Care

Metro: All

Status: D,P

Type: All

Date of Last Update: All Dates

HPSA Score: From 0 To 26

Collapse All



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07 items in 01 page

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	1479994793	Christ Community Health Services, Inc.	Primary Care	Comprehensive Health Center			18	Designated	01/14/2013
Shelby County	157	1479994795	Memp his Health Center, Inc.	Primary Care	Comprehensive Health Center			17	Designated	11/04/2010
Shelby County	157	1477429209	Federal Correctional Institution - Memphis	Primary Care	Correctional Facility		0	12	Designated	12/30/2015
Shelby County	157	1479994706	Low income - Frayser/Raleigh	Primary Care	HPSA Population	Low Income Population HPSA	31	10	Designated	12/04/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	100		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	101.10		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	101.20		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	102.10		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	102.20		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	103		Primary Care	Census Tract			Designated	12/04/2013

HPSA Find Results

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update
1	Page Size: 20								07/26/2016 in 01 pe
Shelby County	157	11		Primary Care	Census Tract			Designate	12/04/2013
<u>County Name</u>	<u>County FIPS Code</u>	<u>HPSA ID</u>	<u>HPSA Name</u>	<u>HPSA Discipline Class</u>	<u>Designation Type</u>	<u>HPSA FTE</u>	<u>HPSA Score</u>	<u>HPSA Status</u>	<u>HPSA Designation Last Update</u>
Shelby County	157	111		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	112		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	113		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	12		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	13		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	14		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	15		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	17		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	19		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	2		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	20		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.11		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.12		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.21		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.23		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.24		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.31		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.32		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.41		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	205.42		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	206.21		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	206.44		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	206.51		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	21		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	24		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	25		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	27		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	28		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	3		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	30		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	36		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	4		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	6		Primary Care	Census Tract			Designate	12/04/2013
Shelby County	157	7		Primary Care	Census Tract			Designate	12/04/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
1	Page Size: 20								07 Results in 01 page
Shelby County	157	8		Primary Care	Census Tract			Designated	12/04/2013
County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	89		Primary Care	Census Tract			Designated	
Shelby County	157	9		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	99,01		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	99,02		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	1479994707	Low Income - Southwest Memphis	Primary Care	HPSA Population	37	16	Designated	06/03/2014

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	105		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	106,10		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	106,20		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	106,30		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	108,10		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	110,10		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	110,20		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	114		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	115		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	116		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	117		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	118		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	217,31		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	219		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	220,22		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	220,23		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	220,24		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	221,11		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	221,12		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	221,21		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	221,22		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	221,30		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	222,10		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	222,20		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	223,10		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	223,21		Primary Care	Census Tract			Designated	06/03/2014

HPSA Find Results

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date	
1	Page Size: 20								07/03/2014 in 01 pe	
Shelby County	157	223.22		Primary Care	Census Tract			Designate	06/03/2014	
<u>County Name</u>	<u>County FIPS Code</u>	<u>HPSA ID</u>	<u>HPSA Name</u>	<u>HPSA Discipline Class</u>	<u>Designation Type</u>	<u>Population</u>	<u>HPSA FTE</u>	<u>HPSA Score</u>	<u>HPSA Status</u>	<u>HPSA Designation Last Update Date</u>
Shelby County	157	223.30		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	224.10		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	225		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	226		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	227		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	37		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	38		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	39		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	45		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	46		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	50		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	53		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	55		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	56		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	57		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	58		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	59		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	60		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	62		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	63		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	64		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	65		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	66		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	67		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	68		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	69		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	70		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	73		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	74		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	75		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	78.10		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	78.21		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	78.22		Primary Care	Census Tract			Designate	06/03/2014	
Shelby County	157	79		Primary Care	Census Tract			Designate	06/03/2014	

HPSA Find Results

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
1	Page Size: 20								07/31/2017 in 01 ps
Shelby County	157	80		Primary Care	Census Tract			Designate d	06/03/2014
County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	81.10		Primary Care	Census Tract			Designate d	06/03/2014
Shelby County	157	81.20		Primary Care	Census Tract			Designate d	06/03/2014
Shelby County	157	82		Primary Care	Census Tract			Designate d	06/03/2014
Shelby County	157	9801		Primary Care	Census Tract			Designate d	06/03/2014
Shelby County	157	147999470A	Low Income - Parkway Village/Fox Meadows	Primary Care	HPSA Population	3	12	Designated	01/31/2014
County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	107.10		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	107.20		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	108.20		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.10		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.21		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.24		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.25		Primary Care	Census Tract			Designate d	01/31/2014
County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	217.26		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.32		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.41		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.44		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.45		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.46		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.47		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.51		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.52		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.53		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	217.54		Primary Care	Census Tract			Designate d	01/31/2014
Shelby County	157	1479994700	Tri State Community Health Center	Primary Care	Comprehensive Health Center	22		Designated	07/31/2017
1	Page Size: 20								07 items in 01 ps

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee – they are not listed separately.



August 11, 2017

J. Richard Wagers, Jr.
Senior Executive Vice President & CFO
Regional One Health
877 Jefferson Avenue
Memphis, TN 38103

Dear Mr. Wagers,

This six bed project will involve only minimal cost to change out signage, etc. Further, to the best of our knowledge, the project provides a physical environment compliant with all applicable federal, state and local construction codes, standards, specifications, and requirements, and the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the 2014 AIA Guidelines for Design and Construction of Hospitals and Outpatient Facilities.

Sincerely,

A handwritten signature in cursive script that reads "Warren N. Goodwin".

Warren N. Goodwin, FAIA
President & CEO

Cc: Graham Baker



August 11, 2017

Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

RE: Regional Med Extended Care Hospital, LLC d/b/a Regional One Health Extended Care Hospital

Mrs. Hill,

I am the Administrator/CEO of Regional Med Extended Care Hospital d/b/a Regional One Health Extended Care Hospital. Our latest financials, submitted with our Certificate of Need application, indicate that we have sufficient cash reserves to fund this \$355,000 project. While the projected cost of the project exceeds \$2 million, the remainder will be provided for under a lease arrangement.

This is to notify you that our cash reserves are available for this project. Please do not hesitate to contact me with any questions at (901) 515-3030 or via email at mkelly@regionalonehealth.org.

Sincerely,



Mark A. Kelly
Administrator and CEO



SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Basic Financial Statements and Schedules

June 30, 2016 and 2015

(With Independent Auditors' Report Thereon)

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

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KPMG LLP
Triad Centre III
Suite 450
6070 Poplar Avenue
Memphis, TN 38119-3901

Independent Auditors' Report

The Board of Directors
Shelby County Health Care Corporation:

We have audited the accompanying statements of net position and statements of revenues, expenses, and changes in net position and cash flows of Shelby County Health Care Corporation, a component unit of Shelby County, Tennessee (d/b/a Regional One Health) as of and for the years ended June 30, 2016 and 2015, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective net position of Shelby County Health Care Corporation as of June 30, 2016 and 2015, and the respective changes in net position and cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.



Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise Shelby County Health Care Corporation's basic financial statements. The supplementary information included in schedules 1, 2, 3, 4, 5, 6, and 7 is presented for the purpose of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information, except for the portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements as a whole.

Management has omitted management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 11, 2016, on our consideration of Shelby County Health Care Corporation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Shelby County Health Care Corporation's internal control over financial reporting and compliance.

KPMG LLP

Memphis, Tennessee
November 11, 2016

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Net Position

June 30, 2016 and 2015

Assets	2016	2015
Assets:		
Cash and cash equivalents	\$ 16,710,050	9,764,159
Investments	111,841,180	109,959,639
Patient accounts receivable, net of allowances for uncollectible accounts of \$130,031,000 in 2016 and \$169,265,000 in 2015	64,422,437	68,627,756
Other receivables	13,811,415	10,968,415
Other current assets	7,282,171	7,035,719
Total current assets	214,067,253	206,355,688
Restricted cash	437,060	514,785
Restricted investments	6,062,721	6,901,313
Equity investments	12,980,671	10,999,876
Notes receivable	19,221,600	19,221,600
Capital assets, net	90,988,913	96,007,465
Total assets	\$ 343,758,218	340,000,727
Liabilities and Net Position		
Liabilities:		
Accounts payable	\$ 14,452,736	14,092,765
Accrued expenses and other current liabilities	44,527,850	38,317,676
Total current liabilities	58,980,586	52,410,441
Accrued professional and general liability costs	2,426,000	4,530,000
Obligation under reverse repurchase agreement	11,893,738	—
Net postemployment benefit obligation	960,000	750,000
Notes payable	26,550,000	26,550,000
Total liabilities	100,810,324	84,240,441
Net position:		
Net investment in capital assets	64,438,913	69,457,465
Restricted for:		
Capital assets	1,896,509	2,855,282
Indigent care	702,167	834,684
Notes payable	437,060	514,785
Unrestricted	175,473,245	182,098,070
Total net position	242,947,894	255,760,286
Total liabilities and net position	\$ 343,758,218	340,000,727

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Revenues, Expenses, and Changes in Net Position

Years ended June 30, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Operating revenues:		
Net patient service revenue (including additional incremental reimbursement from various state agencies for participation in TennCare/Medicaid programs of approximately \$74,008,000 in 2016 and \$67,387,000 in 2015)	\$ 362,356,166	347,134,962
Other revenue	<u>33,331,773</u>	<u>26,239,916</u>
Total operating revenues	<u>395,687,939</u>	<u>373,374,878</u>
Operating expenses:		
Salaries and benefits	191,513,277	179,221,725
Supplies and services	93,353,541	84,128,275
Physician and professional fees	26,080,862	25,475,185
Purchased medical services	56,015,982	44,448,420
Plant operations	14,630,265	13,783,854
Insurance	422,542	2,843,248
Administrative and general	38,928,298	34,746,038
Community services	933,161	757,581
Depreciation	<u>18,571,929</u>	<u>18,204,987</u>
Total operating expenses	<u>440,449,857</u>	<u>403,609,313</u>
Operating loss	<u>(44,761,918)</u>	<u>(30,234,435)</u>
Nonoperating revenues (expenses):		
Interest expense	(397,898)	(347,791)
Investment income	3,066,749	3,578,035
Appropriations from Shelby County	27,408,000	26,816,000
Other	<u>1,872,675</u>	<u>8,730,159</u>
Total nonoperating revenues, net	<u>31,949,526</u>	<u>38,776,403</u>
Increase (decrease) in net position	<u>(12,812,392)</u>	<u>8,541,968</u>
Net position, beginning of year	<u>255,760,286</u>	<u>247,218,318</u>
Net position, end of year	<u>\$ 242,947,894</u>	<u>255,760,286</u>

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Cash Flows

Years ended June 30, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Cash flows from operating activities:		
Receipts from and on behalf of patients and third-party payors	\$ 367,284,642	335,009,290
Other cash receipts	33,212,527	25,607,911
Payments to suppliers	(232,319,636)	(208,312,598)
Payments to employees and related benefits	(186,503,501)	(180,016,276)
Net cash used in operating activities	<u>(18,325,968)</u>	<u>(27,711,673)</u>
Cash flows from noncapital financing activity:		
Appropriations received from Shelby County	<u>25,328,013</u>	<u>26,816,000 *</u>
Net cash provided by noncapital financing activity	<u>25,328,013</u>	<u>26,816,000</u>
Cash flows from capital and related financing activities:		
Capital expenditures	(13,661,497)	(11,893,966)
Proceeds from pledges	—	22,169
Proceeds from sale of capital assets	—	31,398
Interest payments	(389,920)	(351,916)
Net cash used in capital and related financing activities	<u>(14,051,417)</u>	<u>(12,192,315)</u>
Cash flows from investing activities:		
Purchases of investments	(300,665,214)	(238,329,755)
Proceeds from sale of investments	312,242,913	249,085,424
Investment in equity investees	—	(1,300,000)
Investment income proceeds	<u>2,339,839</u>	<u>3,345,720</u>
Net cash provided by investing activities	<u>13,917,538</u>	<u>12,801,389</u>
Net increase (decrease) in cash and cash equivalents	6,868,166	(286,599)
Cash and cash equivalents, beginning of year	<u>10,278,944</u>	<u>10,565,543</u>
Cash and cash equivalents, end of year	<u>\$ 17,147,110</u>	<u>10,278,944</u>

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Cash Flows
Years ended June 30, 2016 and 2015

	<u>2016</u>	<u>2015</u>
Reconciliation of operating loss to net cash used in operating activities:		
Operating loss	\$ (44,761,918)	(30,234,435)
Adjustment to reconcile operating loss to net cash used in operating activities:		
Depreciation	18,571,929	18,204,987
Changes in operating assets and liabilities:		
Patients accounts receivable, net	4,205,319	(20,725,209)
Other receivables	(763,013)	937,865
Other current assets	(246,452)	(786,317)
Accounts payable	359,971	6,069,016
Accrued expenses and other current liabilities	6,202,196	(855,580)
Accrued professional and general liability costs	(2,104,000)	(322,000)
Net postemployment benefit obligation	210,000	—
Net cash used in operating activities	<u>\$ (18,325,968)</u>	<u>(27,711,673)</u>
Reconciliation of cash and cash equivalents to the statements of net position:		
Cash and cash equivalents in current assets	\$ 16,710,050	9,764,159
Cash and cash equivalents held for payment of outstanding debt fees	<u>437,060</u>	<u>514,785</u>
Total cash and cash equivalents	<u>\$ 17,147,110</u>	<u>10,278,944</u>
Supplemental schedule of noncash investing and financing activities:		
Net decrease in the fair value of investments	\$ (619,180)	(347,515)
Equity in net income of equity investees	1,980,795	8,707,269
(Loss) gain on capital asset disposals	(108,121)	721

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

(1) Organization and Summary of Significant Accounting Policies

Shelby County Health Care Corporation (d/b/a Regional One Health) was incorporated on June 15, 1981, with the approval of the Board of County Commissioners of Shelby County, Tennessee (the County). Regional One Health is a broad continuum healthcare provider that operates facilities owned by the County under a long-term lease. The lease arrangement effectively provided for the transfer of title associated with operating fixed assets and the long-term lease (for a nominal amount) of related real property. The lease expires in 2063.

Regional One Health is a component unit of the County as defined by Governmental Accounting Standards Board (GASB) Statement No. 61, *The Financial Reporting Entity: Omnibus – an amendment of GASB Statement No. 14 and No. 34*. Regional One Health's component unit relationship to the County is principally due to financial accountability and financial benefit or burden as defined in GASB Statement No. 61. Regional One Health is operated by a 15-member board of directors, all of whom are appointed by the Mayor of the County and approved by the County Commission.

Regional One Health Foundation is a component unit of Regional One Health principally due to Regional One Health's financial accountability and financial benefit or burden for Regional One Health Foundation as defined in GASB Statement No. 61. Regional One Health Foundation is operated by a board of directors, all of whom are appointed by Regional One Health's board. Regional One Health Foundation is a blended component unit of Regional One Health because it provides services entirely to Regional One Health. Regional One Health Foundation issues separate audited financial statements, which can be obtained by writing to Regional Medical Center Foundation, 877 Jefferson Avenue, Memphis, Tennessee 38103 or by calling 901-545-7482.

GASB Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments*, requires a management's discussion and analysis (MD&A) section providing an analysis of Regional One Health's overall financial position and results of operations; however, Regional One Health has chosen to omit the MD&A from these accompanying financial statements.

The significant accounting policies used by Regional One Health in preparing and presenting its financial statements follow:

(a) Presentation

The financial statements include the accounts of Regional One Health and its wholly owned subsidiaries. Such subsidiaries include Regional One Properties, Inc., Regional Med Extended Care Hospital, LLC, and Shelby County Health Care Properties, Inc. All material intercompany accounts and transactions have been eliminated.

(b) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires that management make estimates and assumptions affecting the reported amounts of assets, liabilities, revenues, and expenses, as well as disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

Significant items subject to estimates and assumptions include the determination of the allowances for contractual adjustments and uncollectible accounts, reserves for professional and general liability claims, reserves for employee healthcare claims, net postretirement benefit cost and obligation, and estimated third-party payor settlements.

In addition, laws and regulations governing Medicare, TennCare, and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates related to these programs will change by a material amount in the near term.

(c) Enterprise Fund Accounting

Regional One Health's financial statements are prepared using the economic resources measurement focus and accrual basis of accounting.

(d) Cash Equivalents

Regional One Health considers investments in highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents.

(e) Investments and Investment Income

Investments are carried at fair value, principally based on quoted market prices. Investment income (including realized and unrealized gains and losses) from investments is reported as nonoperating revenue.

(f) Inventories

Inventories, consisting principally of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out method) or replacement market.

(g) Equity Investments

Equity investments consist of Regional One Health's equity interests in investments as measured by its ownership interest if Regional One Health has an ongoing financial interest in or ongoing financial responsibility for the equity investee. The investments are initially recorded at cost and are subsequently adjusted for additional contributions, distributions, undistributed earnings and losses, and impairment losses.

(h) Capital Assets

Capital assets are recorded at cost, if purchased, or at fair value at the date of donation. Depreciation is provided over the useful life of each class of depreciable asset using the straight-line method. Maintenance and repairs are charged to operations. Major renewals and betterments are capitalized. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and the gain or loss, if any, is included in nonoperating revenues (expenses) in the accompanying statements of revenues, expenses, and changes in net position.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

Regional One Health capitalizes interest cost on qualified construction expenditures, net of income earned on related trustee assets, as a component of the cost of related projects. No such interest costs were capitalized in 2016 or 2015.

All capital assets other than land are depreciated using the following lives:

Land improvements	5 to 25 years
Buildings and improvements	10 to 40 years
Fixed equipment	5 to 25 years
Movable equipment	3 to 20 years
Software	3 years

(i) Impairment of Capital Assets

Capital assets are reviewed for impairment when service utility has declined significantly. If such assets are no longer used, they are reported at the lower of carrying value or fair value. If such assets will continue to be used, the impairment loss is measured using the method that best reflects the diminished service utility of the capital asset. No charge related to impairment matters was required during 2016 or 2015.

(j) Compensated Absences

Regional One Health's employees accumulate vacation, holiday, and sick leave at varying rates depending upon years of continuous service and payroll classification, subject to maximum limitations. Upon termination of employment, employees are paid all unused accrued vacation and holiday time at regular rate of pay up to a designated maximum number of days. Since the employees' vacation and holiday time accumulates and vests, an accrual for this liability is included in accrued expenses and other current liabilities in the accompanying statements of net position. An accrual is recognized for unused sick leave expected to be paid to employees eligible to retire.

(k) Net Position

Net position of Regional One Health is classified into the following components:

- *Net investment in capital assets* consists of capital assets net of accumulated depreciation, net of the related debt.
- *Restricted* includes those amounts with limits on their use that are externally imposed (by creditors, grantors, contributors, or the laws and regulations of other governments).
- *Unrestricted* represents remaining amounts that do not meet either of the above definitions.

When Regional One Health has both restricted and unrestricted resources available to finance a particular program, it is Regional One Health's policy to use restricted resources before unrestricted resources.

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

Regional One Health Foundation historically and to-date does not maintain donor-restricted endowment funds, or any Board-designated endowments. Regional One Health Foundation's Board has interpreted Tennessee's State Prudent Management of Institutional Funds Act as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. In all material respects, income from Regional One Health Foundation's donor-restricted endowment funds is itself restricted to specific donor-directed purposes, and is, therefore, accounted for within restricted amounts until expended in accordance with the donor's wishes. Regional One Health Foundation oversees individual donor-restricted endowment funds to ensure that the fair value of the original gift is preserved.

(l) *Statement of Revenues, Expenses, and Changes in Net Position*

For purposes of presentation, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services, other than financing costs, are reported as operating revenues and operating expenses. Other transactions, such as investment income, interest expense, appropriations from Shelby County, gain (loss) on disposal of capital assets, and equity in earnings are reported as nonoperating revenues and expenses.

(m) *Net Patient Service Revenue*

Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations. Changes in estimates related to prior cost reporting periods resulted in an increase in net patient service revenue of approximately \$1,332,000 and \$587,000 in 2016 and 2015, respectively.

(n) *Charity Care*

Regional One Health provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because Regional One Health does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

When defining charity care, Regional One Health employs the Federal Poverty Guideline (FPG) to determine the level of discount uninsured patients receive. The level by which assistance is determined is through the scale set by the Department of Health and Human Services, which includes factors such as residents per household and income. Regional One Health's methodology includes all patients that fall at or below the 150% FPG baseline. Regional One Health does not have a cap to which patients will not qualify for a discount. Additionally, Regional One Health's charity care guidelines provide for an expansive definition of charity care patients, including an upfront discount from standard charges for uninsured patients.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

(o) *Income Taxes*

Regional One Health is a not-for-profit corporation organized by the approval of the Board of County Commissioners of the County and qualifies as a tax-exempt entity under Internal Revenue Code (IRC) Section 501(a) as organizations described in IRC Section 501(c)(3), and therefore, related income is generally not subject to federal or state income taxes, except for tax on income from activities unrelated to its exempt purpose as described in IRC Section 512(a). Thus, no provision for income taxes has been recorded in the accompanying financial statements.

(p) *Appropriations*

The County has historically appropriated funds annually to Regional One Health to partially offset the cost of medical care for indigent residents of the County. Appropriations for indigent residents from the County were \$27,408,000 and \$26,816,000 for the years ended June 30, 2016 and 2015, respectively. Appropriations from the County are reported as nonoperating revenue in the accompanying statements of revenues, expenses, and changes in net position.

(q) *Recent Accounting Pronouncements*

In February 2015, the GASB issued Standard 72: *Fair Value Measurement and Application*, which addresses the accounting and financial reporting issues related to fair value measurements. This standard defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an ordinary transaction between market participants. GASB 72 requires disclosures to be made about fair value measurements, the level of fair value hierarchy and valuation techniques. Additional disclosures are required regarding investments that are valued by net asset per share. This standard is effective for the financial statements for periods beginning after June 15, 2015 (the Regional One Health 2016 fiscal year). Regional One Health adopted this standard on July 1, 2015. There is no effect on the financial statements related to the adoption of this standard, but additional disclosures are included in note 2 to the financial statements.

(r) *Subsequent Events*

Regional One Health has evaluated subsequent events through November 11, 2016, the date at which the financial statements were issued, and determined that there are no subsequent events to be recognized in the financial statements and related notes.

(s) *Reclassifications*

Certain reclassifications have been made to the 2015 financial statements to conform to the 2016 presentation.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

(2) Deposits, Investments and Reverse Repurchase Agreement

(a) Deposits and Investments

The composition of cash and cash equivalents follows:

	<u>2016</u>	<u>2015</u>
Cash	\$ 16,690,503	9,744,655
Money market funds	19,547	19,504
	<u>\$ 16,710,050</u>	<u>9,764,159</u>

Investments and restricted investments include amounts held by both Regional One Health and Regional One Health Foundation.

The composition of investments and restricted investments follows:

	<u>2016</u>	<u>2015</u>
U.S. agencies	\$ 50,601,257	64,108,405
Certificates of deposit	8,246,030	896,146
Corporate bonds	49,200,185	36,228,983
Demand deposit accounts and money market funds	3,147,369	6,385,686
U.S. government funds	356,578	—
Common stock	5,723,146	8,720,123
Accrued interest	629,336	521,609
	<u>\$ 117,903,901</u>	<u>116,860,952</u>

The fair value hierarchy of investments follows:

	<u>2016</u>			
	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
U.S. agencies	\$ —	50,601,257	—	50,601,257
Certificates of deposit	—	8,246,030	—	8,246,030
Corporate bonds	—	49,200,185	—	49,200,185
Demand deposit accounts and money market funds	—	3,147,369	—	3,147,369
U.S. government funds	—	356,578	—	356,578
Common stock	5,723,146	—	—	5,723,146
Accrued interest	629,336	—	—	629,336
	<u>\$ 6,352,482</u>	<u>111,551,419</u>	<u>—</u>	<u>117,903,901</u>

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

2015				
	Level 1	Level 2	Level 3	Total
U.S. agencies	\$ —	64,108,405	—	64,108,405
Certificates of deposit	—	896,146	—	896,146
Corporate bonds	—	36,228,983	—	36,228,983
Demand deposit accounts and money market funds	—	6,385,686	—	6,385,686
U.S. government funds	—	—	—	—
Common stock	8,720,123	—	—	8,720,123
Accrued interest	521,609	—	—	521,609
	<u>\$ 9,241,732</u>	<u>107,619,220</u>	<u>—</u>	<u>116,860,952</u>

At June 30, 2016, Regional One Health and Regional One Health Foundation had investments in debt securities with the following maturities:

	Fair value	Less than 6 months	6 months to 1 year	1–5 years	Over 5 years
U.S. agencies	\$ 50,601,257	—	—	27,768,700	22,832,557
Corporate bonds	49,200,185	3,378,292	6,376,187	34,405,251	5,040,455
	<u>\$ 99,801,442</u>	<u>3,378,292</u>	<u>6,376,187</u>	<u>62,173,951</u>	<u>27,873,012</u>

At June 30, 2015, Regional One Health and Regional One Health Foundation had investments in debt securities with the following maturities:

Investment and restricted investment maturities (in years)					
	Fair value	Less than 6 months	6 months to 1 year	1–5 years	5+ years
U.S. agencies	\$ 64,108,405	7,005,393	9,655,516	30,139,605	17,307,891
Corporate bonds	36,228,983	564,746	2,669,948	29,654,286	3,340,003
	<u>\$ 100,337,388</u>	<u>7,570,139</u>	<u>12,325,464</u>	<u>59,793,891</u>	<u>20,647,894</u>

There were no investments that represented 5% or more of total investments for Regional One Health as of June 30, 2016 and 2015. At June 30, 2016, Regional One Health Foundation had one investment totaling \$356,578 in the SEI Daily Income Trust Government Fund that represented 5% or more of total investments for Regional One Health Foundation. At June 30, 2015, Regional One Health Foundation had one investment totaling \$512,878 in the SEI Daily Income Trust Government Fund that represented 5% or more of total investments for Regional One Health Foundation.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

Regional One Health and Regional One Health Foundation have separate investment policies that are included below. The summary of investments throughout the financial statements includes the combined investment totals of Regional One Health and Regional One Health Foundation.

At June 30, 2016, Regional One Health's and Regional One Health Foundation's corporate bonds, collectively, had the following credit ratings per Standard and Poor's:

	<u>Fair value</u>	<u>Credit rating</u>
\$	6,678,364	BBB-
	6,559,437	BBB
	17,069,371	BBB+
	472,500	BB
	5,418,430	A-
	9,487,056	A
	921,745	A+
	2,389,373	AA-
	—	AA+
	<u>203,909</u>	
\$	<u><u>49,200,185</u></u>	

At June 30, 2015, Regional One Health's and Regional One Health Foundation's corporate bonds, collectively, had the following credit ratings per Standard and Poor's:

	<u>Fair value</u>	<u>Credit rating</u>
\$	4,784,327	BBB-
	6,717,033	BBB
	6,345,414	BBB+
	7,610,862	A-
	8,436,865	A
	895,896	A+
	1,159,164	AA-
	<u>279,422</u>	AA+
\$	<u><u>36,228,983</u></u>	

As of June 30, 2016, Regional One Health's investment strategy, per its investment policy, is to provide liquidity to fund ongoing operating needs and to act as a repository for both the accumulation

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Notes to Basic Financial Statements

June 30, 2016 and 2015

of cash reserves needed to cushion economic down cycles and to provide cash earmarked for strategic needs.

The portfolio objectives of Regional One Health, listed in order of importance, are as follows:

1. Preserve principal
2. Maintain sufficient liquidity to meet future cash needs
3. Maintain a diversified portfolio to minimize risk
4. Maximize return subject to the above criteria

The duration of the bond investment portfolio should not exceed six years.

The authorized investments are as follows:

1. *Commercial Paper* – Any commercial paper issued by a domestic corporation with a maturity of 270 or less days that carries at least the second highest rating by a recognized investor service, preferably Standard and Poor's and Moody's Investors Service. Commercial paper shall not represent more than 50% of the portfolio.
2. *U.S. Treasury Securities* – U.S. Treasury notes, bills, and bonds. There is no upper limit restriction as to the maximum dollar amount or percentage of the portfolio that may be invested in U.S. Treasury securities.
3. *Bank Obligations* – Any certificate of deposit, time deposit, Eurodollar CD issued by a foreign branch of a U.S. bank, bankers' acceptance, bank note, or letter of credit issued by a (U.S.) bank possessing at least the second highest rating by a recognized investor services, preferably Standard and Poor's and Moody's Investors Service. Bank obligations (excluding repurchase agreements, commercial paper, and investments held by money market and mutual funds) may not represent more than 30% of the portfolio. In addition, brokered CDs may be purchased from institutions, irrespective of the institutions' debt ratings, so long as the obligations are fully backed by the FDIC.
4. *Repurchase Agreements* – Any Repurchase Agreement purchased from one of the top 25 U.S. banks or one of the primary dealers regulated by the Federal Reserve that is at least 102% collateralized by U.S. government obligations. Repurchase Agreements may not represent more than 20% of the portfolio.
5. *Money Market Funds* – Any open-end money market fund regulated by the U.S. government under Investment Company Act Rule 2a-7. Any investment fund regulated by a Registered Investment Advisor under Rule 3c-7. Such fund investment guidelines must state that "the fund will seek to maintain a \$1 per share net asset value." Regional One Health's investment in any one fund may not exceed 30% of the assets of the fund into which it is invested.

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6. *United States Government Obligations* – Any obligation issued or backed (federal agencies) by the U.S. government. No more than 25% may be invested in obligations of any one federal agency.
7. *Corporate Bonds* – Obligations of United States and foreign corporations (including trusts and municipalities of the United States) that carry at least the fourth highest rating by a recognized rating service, preferably Standard and Poor's or Moody's Investors Service. Corporate bonds, held directly and initially qualifying in one of the above categories, which have been downgraded below the third highest rating, may be sold at the discretion of management. Corporate bonds may not represent more than 40% of the portfolio, foreign corporate bonds may not represent more than 20% of the portfolio, and corporate bonds in the fourth highest rating category may not represent more than 20% of the portfolio.
8. *Bond Mutual Funds* – Any publicly available investment registered under the Investment Company Act of 1940 as an open-end mutual fund that is managing a portfolio or debt obligations. Each mutual fund should have a minimum of \$2 billion invested and hold at least 100 different debt obligations. Bond mutual funds can only hold the Authorized Investments meeting all the criteria described above. Additionally, bond mutual funds can hold corporate bonds in the fifth and sixth highest ratings category as long as such holdings do not exceed 10% of the portfolio. Corporate bonds, held via bond mutual funds and initially qualifying in one of the above categories, which have been downgraded below the sixth highest rating, may not exceed 2% of the portfolio.
9. *Equity Mutual Funds* – Any publicly available investment registered under the Investment Company Act of 1940 as an open-end mutual fund that is managing a portfolio of equity securities. Each mutual fund should have a minimum of \$2 billion invested and hold at least 100 different equity securities. Such holdings should not represent more than 20% of the portfolio, Equity Mutual Funds can hold equity securities (including common and preferred stocks) of the 1,000 largest corporations in terms of market capitalization and inclusion in the Russell 1000 Index (representing large cap stocks) that are traded on U.S. exchanges reported in the Wall Street Journal.
10. *Debt Buy Back* – Any debt obligation backed directly by Regional One Health may be purchased so long as it is purchased at a discount.
11. Notwithstanding the above criteria, direct investments other than mutual funds that meet the following criteria are not permitted: corporations with more than 25% of revenues derived from the manufacture and sale of firearms, ammunition, and ammunition magazines to the general citizenry.

The Finance Committee of the Board of Directors meets periodically to review asset allocation, portfolio performance, and overall adherence to the investment policy guidelines.

As of June 30, 2016 and 2015, Regional One Health Foundation utilized one investment manager. This manager is required to make investments in adherence to Regional One Health Foundation's current investment policy and objectives.

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Regional One Health Foundation follows an investment strategy focused on maximizing total return (i.e., aggregate return from capital appreciation and dividend and interest income) while adhering to certain restrictions designed to promote a conservative portfolio.

Specifically, the primary objective of Regional One Health Foundation's investment management strategy is to maintain an investment portfolio designed to generate a high level of current income with above-average stability.

Guidelines for investments and cash equivalents for Regional One Health Foundation follow:

1. Regional One Health Foundation's assets may be invested only in investment grade bonds rated Baa or higher as determined by Moody's Investors Service, or the equivalent by another acceptable rating agency.
2. The overall market-weighted quality rating of the bond portfolio shall be no lower than A.
3. Regional One Health Foundation's assets may be invested only in commercial paper rated P-2 (or equivalent) or higher by Moody's Investors Service or by another acceptable rating agency.
4. The market-weighted maturity of the base portfolio shall be no longer than 10 years.
5. Quality of the equity securities will be governed by the Federal Employee Retirement and Income Security Act, the Tennessee guidelines for investing trust funds and the "prudent man rule."
6. Conservative option strategies may be used, with a goal of increasing the stability of the portfolio.

Regional One Health Foundation limits investments in common stock to 40% of its investment portfolio. The remainder of the portfolio is to be invested in fixed-income investments.

Investment income comprises the following:

	2016	2015
Dividend and interest income	\$ 3,685,929	3,925,550
Net decrease in fair value of investments	(619,180)	(347,515)
	<u>\$ 3,066,749</u>	<u>3,578,035</u>

(b) Reverse Repurchase Agreement

In November 2013, Regional One Health entered into a Master Repurchase Agreement with a financial institution which allows Regional One Health to enter into transactions using reverse repurchase agreements, whereas Regional One Health in exchange for a predetermined amount cash, sells or pledges (i.e., reverse repurchases) its own investments (with a market value approximately 5% higher than the predetermined amount) and agrees to repurchase the investments at a future date or on demand for the same predetermined amount of cash plus interest for the period between the two transaction

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dates. Also, Regional One Health is entitled to any maturity or interest payments received on the investments subject to the reverse repurchase agreement (prior to repurchase) and occasionally Regional One Health's investments are substituted, especially when they are redeemed by the issuer.

Regional One Health uses these agreements as a cash management strategy primarily related to the \$50,000,000 cash influx received in July each year, from the County and State appropriations, that is used by operations over the remainder of the fiscal year. Therefore, it allows Regional One Health to invest this excess working capital cash for longer periods of time at rates higher than the interest charged under the reverse repurchase agreements. Consequently, the outstanding amount of repurchase obligations can be as high as \$50,000,000 during any given fiscal year and should be zero shortly following the \$50,000,000 cash influx in July.

These transactions are formally approved within the investment policy of Regional One Health and the Master Repurchase Agreement, which stays in effect with the financial institution, until either party terminates. There were no violations of the Master Repurchase Agreement or the Regional One Health investment policy during the years ended June 30, 2016 and 2015.

During the fiscal year ended June 30, 2016, the outstanding balance of reverse repurchase agreement obligations ranged between zero and approximately \$45,000,000, and was \$11,893,738 at June 30, 2016, which is reported as a liability obligation under reverse repurchase agreements on the statement of net position. During the fiscal year ended June 30, 2015, the outstanding balance of reverse repurchase agreement obligations ranged between zero and approximately \$40,000,000, and there was no outstanding obligations at June 30, 2015. Interest expense related to the reverse repurchase agreements was \$132,000 and \$82,000 for the years ended June 30, 2016 and 2015, respectively, and is reported within interest expense on the statements of revenues, expenses and changes in net position. In July 2016, Regional One Health repurchased the outstanding reverse repurchase agreement obligations of \$11,893,738 as of June 30, 2016.

(3) Business and Credit Concentrations

Regional One Health grants credit to patients, substantially all of whom are local area residents. Regional One Health generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, and commercial insurance policies).

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The mix of receivables from patients and third-party payors follows, before application of related valuation allowances:

	<u>2016</u>	<u>2015</u>
Patients	32%	33%
Commercial insurance	30	29
Medicare	21	19
Medicaid/TennCare	17	19
	<u>100%</u>	<u>100%</u>

(4) Other Receivables

The composition of other receivables follows:

	<u>2016</u>	<u>2015</u>
Accounts receivable from University of Tennessee Center for Health Services	\$ 1,497,523	1,741,599
Accounts receivable from the County	2,234,667	154,680
Accounts receivable from the State of Tennessee	4,435,272	3,547,429
Grants receivable	343,803	1,025,254
Accounts receivable from UT Regional One Physicians	1,648,543	1,295,526
Other	3,651,607	3,203,927
	<u>\$ 13,811,415</u>	<u>10,968,415</u>

(5) Other Current Assets

The composition of other current assets follows:

	<u>2016</u>	<u>2015</u>
Inventories	\$ 3,383,077	3,280,696
Prepaid expenses	3,899,094	3,755,023
	<u>\$ 7,282,171</u>	<u>7,035,719</u>

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(6) Capital Assets

Capital assets and related activity consist of the following:

	<u>Balances at June 30, 2015</u>	<u>Additions</u>	<u>Retirements</u>	<u>Transfers</u>	<u>Balances at June 30, 2016</u>
Capital assets not being depreciated:					
Construction in progress	\$ 2,871,413	7,643,499	—	(9,449,804)	1,065,108
Land	4,313,278	—	—	—	4,313,278
Total book value of capital assets not being depreciated	<u>7,184,691</u>	<u>7,643,499</u>	<u>—</u>	<u>(9,449,804)</u>	<u>5,378,386</u>
Capital assets being depreciated:					
Land improvements	7,390,983	—	—	63,149	7,454,132
Buildings	66,758,749	—	—	—	66,758,749
Fixed equipment	141,514,569	1,417,446	—	3,895,583	146,827,598
Movable equipment	155,015,751	3,631,073	—	2,859,061	161,505,885
Software	36,230,377	969,479	(129,744)	2,632,011	39,702,123
Total book value of capital assets being depreciated	<u>406,910,429</u>	<u>6,017,998</u>	<u>(129,744)</u>	<u>9,449,804</u>	<u>422,248,487</u>
Less accumulated depreciation for:					
Land improvements	(5,961,366)	(186,154)	—	—	(6,147,520)
Buildings	(58,019,940)	(693,881)	—	—	(58,713,821)
Fixed equipment	(102,415,516)	(5,076,784)	—	—	(107,492,300)
Movable equipment	(128,303,012)	(8,446,819)	—	—	(136,749,831)
Software	(23,387,821)	(4,168,291)	21,624	—	(27,534,488)
Total accumulated depreciation	<u>(318,087,655)</u>	<u>(18,571,929)</u>	<u>21,624</u>	<u>—</u>	<u>(336,637,960)</u>
Capital assets being depreciated, net	<u>88,822,774</u>	<u>(12,553,931)</u>	<u>(108,120)</u>	<u>9,449,804</u>	<u>85,610,527</u>
Capital assets, net	<u>\$ 96,007,465</u>	<u>(4,910,432)</u>	<u>(108,120)</u>	<u>—</u>	<u>90,988,913</u>

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	Balances at June 30, 2014	Additions	Retirements	Transfers	Balances at June 30, 2015
Capital assets not being depreciated:					
Construction in progress	\$ 1,585,034	5,039,260	—	(3,752,881)	2,871,413
Land	5,835,326	—	—	(1,522,048)	4,313,278
Total book value of capital assets not being depreciated	<u>7,420,360</u>	<u>5,039,260</u>	<u>—</u>	<u>(5,274,929)</u>	<u>7,184,691</u>
Capital assets being depreciated:					
Land improvements	7,269,474	121,509	—	—	7,390,983
Buildings	65,236,701	—	—	1,522,048	66,758,749
Fixed equipment	138,900,279	1,801,265	—	813,025	141,514,569
Movable equipment	150,758,409	4,084,035	(223,349)	396,656	155,015,751
Software	32,839,280	847,897	—	2,543,200	36,230,377
Total book value of capital assets being depreciated	<u>395,004,143</u>	<u>6,854,706</u>	<u>(223,349)</u>	<u>5,274,929</u>	<u>406,910,429</u>
Less accumulated depreciation for:					
Land improvements	(5,786,325)	(175,041)	—	—	(5,961,366)
Buildings	(57,310,792)	(709,148)	—	—	(58,019,940)
Fixed equipment	(97,386,461)	(5,029,055)	—	—	(102,415,516)
Movable equipment	(119,918,449)	(8,577,235)	192,672	—	(128,303,012)
Software	(19,673,313)	(3,714,508)	—	—	(23,387,821)
Total accumulated depreciation	<u>(300,075,340)</u>	<u>(18,204,987)</u>	<u>192,672</u>	<u>—</u>	<u>(318,087,655)</u>
Capital assets being depreciated, net	<u>94,928,803</u>	<u>(11,350,281)</u>	<u>(30,677)</u>	<u>5,274,929</u>	<u>88,822,774</u>
Capital assets, net	\$ <u>102,349,163</u>	<u>(6,311,021)</u>	<u>(30,677)</u>	<u>—</u>	<u>96,007,465</u>

(7) Equity Investments

The composition of equity method investments follows:

	2016	2015
Investment in Memphis Medical Center Air Ambulance Service, Inc. (MMCAAS)	\$ 10,614,448	8,586,001
Regional One RH MOB 1 SPE, LLC	1,066,223	1,113,875
Investment in Central Billing Office	<u>1,300,000</u>	<u>1,300,000</u>
	\$ <u>12,980,671</u>	<u>10,999,876</u>

MMCAAS is a nonmember not-for-profit corporation organized to operate an air ambulance service for the transportation of medical supplies, equipment, and injured or sick persons. MMCAAS was organized by

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Regional One Health and two other local healthcare systems. Regional One Health appoints one-third of the board members of MMCAAS and is entitled to one-third of the net assets of MMCAAS in the event of dissolution. MMCAAS maintains separate financial statements, which can be obtained by writing to Hospital Wing, 1080 Eastmoreland Avenue, Memphis, Tennessee 38104 or by calling 901-522-5321.

Regional One Properties, Inc., a wholly owned subsidiary of Shelby County Health Care Corporation, is a 50% owner in Regional One RH MOB 1 SPE, LLC. This joint venture with a local developer and other various owners was to purchase an office building in Memphis, Tennessee with intentions of converting this building into medical space and offices. RH MOB 1 SPE, LLC maintains separate financial statements, which can be obtained by writing to 6555 Quince, 3330 Preston Ridge Road, Suite 380, Alpharetta, Georgia 30005 or by calling 404-255-6358 extension 229.

The Central Billing Office (CBO) was formed by Regional One Health and two other local healthcare entities, with Regional One Health being a one-third owner and appointing one-third of the board members. The CBO performs billing and collection services for its three members, including billing for University of Tennessee Regional One Physicians (UTROP) services for Regional One Health. The CBO maintains separate financial statements, which can be obtained by writing to the Partners Central Billing Office, 1407 Union Avenue, Suite 200, Memphis, Tennessee 38104 or by calling 901-275-3702

(8) New Market Tax Credit Program and Long-term Debt

Regional One Health entered into a transaction with SunTrust Community Capital, LLC in September 2013 to obtain financing through the New Market Tax Credit (NMTC) Program sponsored by the Department of Treasury. The NMTC Program permits certain corporate taxpayers to receive a credit against federal income taxes for making qualified equity investments (QEI) in community development entities. The credit provided to the investor totals 39% of the initial value of the QEI and is claimed over a seven-year credit allowance period.

As part of this transaction Regional One Health and SunTrust Community Capital, LLC contributed approximately \$19,222,000 and \$7,328,000, respectively, to The Med Memphis Investment Fund, LLC, an entity created to provide funding for investments in special purposes entities called community development entities (CDEs). Regional One Health provided funding and received a notes receivable as part of the NMTC program as follows:

	<u>2016</u>	<u>2015</u>
Notes receivable	\$ 19,221,600	19,221,600

The notes receivable requires interest only payments of 1.119% annually on the unpaid principal balance, which is due on February 15 following the end of a calendar year, beginning February 15, 2014 through February 15, 2021. Beginning on February 15, 2022, principal and interest payments will be due and will continue annually until the maturity of the notes receivable on February 15, 2035. Additional principal payments are required related to this notes receivable in an amount equal to 90% of net cash flow, as defined in the borrowers operating agreement.

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Shelby County Health Care Properties, Inc. was formed as part of the NMTC Program with Regional One Health as the sole member. Shelby County Health Care Properties, Inc. executed note payable agreements on September 13, 2013 with several CDE's that provide for borrowings of \$26,550,000. The proceeds from these notes payable were used for the expansion of Regional One Health and are treated as a "qualified low-income community investment" for purposes of generating new markets tax credits under Section 45d of the Internal Revenue Code of 1986, as amended.

Long-term debt related to the NMTC program is summarized as follows:

	<u>2016</u>	<u>2015</u>
Note payable to RGC 2, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	\$ 5,500,000	5,500,000
Note payable to NDC New Markets Investments LXXXIII, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	6,790,000	6,790,000
Note payable to CHHS Subsidiary CDE 7, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	7,760,000	7,760,000
Note payable to ST CDE XIV, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	6,500,000	6,500,000
	<u>\$ 26,550,000</u>	<u>26,550,000</u>

A schedule of changes in the long-term debt related to the NMTC program for 2016 follows:

	<u>Date of Issuance</u>	<u>Balance July 1, 2015</u>	<u>Additions</u>	<u>Retired</u>	<u>Balance June 30, 2016</u>	<u>Due within one year</u>
Note payable to RGC 2, LLC	9/13/2013	\$ 5,500,000	—	—	5,500,000	—
Note payable to NDC New Markets Investment LXXXIII, LLC	9/13/2013	6,790,000	—	—	6,790,000	—
Note payable to CHHS subsidiary CDE 7, LLC	9/13/2013	7,760,000	—	—	7,760,000	—
Note payable to ST CDE XIV, LLC	9/13/2013	6,500,000	—	—	6,500,000	—
		<u>\$ 26,550,000</u>	<u>—</u>	<u>—</u>	<u>26,550,000</u>	<u>—</u>

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A schedule of changes in the long-term debt related to the NMTC program for 2015 follows:

	<u>Date of Issuance</u>	<u>Balance July 1, 2014</u>	<u>Additions</u>	<u>Retired</u>	<u>Balance June 30, 2015</u>	<u>Due within one year</u>
Note payable to RGC 2, LLC	9/13/2013	\$ 5,500,000	—	—	5,500,000	—
Note payable to NDC New Markets Investment LXXXIII, LLC	9/13/2013	6,790,000	—	—	6,790,000	—
Note payable to CHHS subsidiary CDE 7, LLC	9/13/2013	7,760,000	—	—	7,760,000	—
Note payable to ST CDE XIV, LLC	9/13/2013	6,500,000	—	—	6,500,000	—
		<u>\$ 26,550,000</u>	<u>—</u>	<u>—</u>	<u>26,550,000</u>	<u>—</u>

The aggregate annual maturities of the long-term debt at June 30, 2016 are as follows:

2017	\$ —
2018	—
2019	—
2020	—
2021	—
Thereafter	<u>26,550,000</u>
	<u>\$ 26,550,000</u>

The annual interest payments associated with long-term debt are as follows:

2017	\$ 265,500
2018	265,500
2019	265,500
2020	556,350
2021	79,597
Thereafter	<u>28,986,051</u>
	<u>\$ 30,418,498</u>

The principal balance is due, for each of the notes payable listed above, in its entirety on the stated maturity date. Interest paid was approximately \$265,500 and \$270,000 in 2016 and 2015, respectively.

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(9) Accrued Expenses and Other Current Liabilities

The composition of accrued expenses and other current liabilities follows:

	<u>2016</u>	<u>2015</u>
Due to third-party payors	\$ 17,624,000	16,013,000
Compensated absences	8,917,099	9,341,125
Deferred grant revenue	248,071	164,375
Accrued payroll and withholdings	12,827,951	7,487,149
Accrued employee healthcare claims	2,808,000	2,715,000
Professional and general liability costs	1,800,000	2,300,000
Other	302,729	297,027
	<u>\$ 44,527,850</u>	<u>38,317,676</u>

(10) Net Patient Service Revenue

Regional One Health has agreements with governmental and other third-party payors that provide for reimbursement to Regional One Health at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between billings at established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with major third-party payors follows:

- *Medicare* – Substantially all acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. Certain types of exempt services and other defined payments related to Medicare beneficiaries are paid based on cost reimbursement or other retroactive-determination methodologies. Regional One Health is paid for retroactively determined items at tentative rates with final settlement determined after submission of annual cost reports by Regional One Health and audits thereof by Regional One Health fiscal intermediary.

Regional One Health's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. Regional One Health's Medicare cost reports have been audited and settled by Regional One Health's fiscal intermediary through June 30, 2013. Revenue from the Medicare program accounted for approximately 24% and 21% of Regional One Health's net patient service revenue for the years ended June 30, 2016 and 2015, respectively.

- *TennCare* – Under the TennCare program, patients traditionally covered by the State of Tennessee Medicaid program and certain members of the uninsured population enroll in managed care organizations that have contracted with the State of Tennessee to ensure healthcare coverage to their enrollees. Regional One Health contracts with the managed care organizations to receive reimbursement for providing services to these patients. Payment arrangements with these managed care organizations consist primarily of prospectively determined rates per discharge, discounts from established charges, or prospectively determined per diem rates. Revenue from the TennCare program

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accounted for approximately 22% of Regional One Health's net patient service revenue for both the years ended June 30, 2016 and 2015.

Regional One Health has historically received incremental reimbursement in the form of Essential Access payments through its participation in the TennCare Program. Amounts received by Regional One Health under this program were approximately \$66,200,000 and \$59,700,000 in 2016 and 2015, respectively. These amounts have been recognized as reductions in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position. There can be no assurance that Regional One Health will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified. Any material reduction in such funds has a correspondingly material adverse effect on Regional One Health's operations.

- *Arkansas Medicaid* – Substantially all inpatient and outpatient services rendered to Arkansas Medicaid program beneficiaries are paid under prospective reimbursement methodologies established by the State of Arkansas. Certain other reimbursement items (principally inpatient nursery services and medical education costs) are based upon cost reimbursement methodologies. Regional One Health is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual cost reports by Regional One Health and audits thereof by the Arkansas Department of Health and Human Services (DHHS). Regional One Health's Arkansas Medicaid cost reports have been audited and settled by the Arkansas DHHS through June 30, 2012. Revenue from the State of Arkansas Medicaid program accounted for approximately 2% of Regional One Health's net patient service revenue for both years ended June 30, 2016 and 2015.

Regional One Health has historically received incremental reimbursement in the form of Upper Payment Limit (UPL) and additional appropriation payments through its participation in the State of Arkansas Medicaid program. The net benefit for Regional One Health associated with this program, totaling approximately \$2,500,000 and \$2,300,000 for the years ended June 30, 2016 and 2015, respectively, has been recognized as a reduction in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position. There can be no assurance that Regional One Health will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified.

- *Mississippi Medicaid* – Inpatient and outpatient services rendered to Mississippi Medicaid program beneficiaries are generally paid based upon prospective reimbursement methodologies established by the State of Mississippi. Revenue from the State of Mississippi Medicaid program accounted for approximately 2% of Regional One Health's net patient service revenue for both the years ended June 30, 2016 and 2015.

Regional One Health has historically received incremental reimbursement in the form of Upper Payment Limit (UPL) and additional appropriation payments through its participation in the State of Mississippi Medicaid program. The net benefit for Regional One Health associated with this program, totaling approximately \$5,400,000 for both the years ended June 30, 2016 and 2015, and has been recognized as a reduction in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position.

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- *Other* – Regional One Health has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The reimbursement methodologies under these agreements include prospectively determined rates per discharge, per diem amounts, and discounts from established charges.

The composition of net patient service revenue follows:

	<u>2016</u>	<u>2015</u>
Gross patient service revenue	\$ 1,152,642,901	1,106,384,701
Less provision for contractual and other adjustments	767,779,648	670,979,457
Less provision for bad debts	22,507,087	88,270,282
Net patient service revenue	<u>\$ 362,356,166</u>	<u>347,134,962</u>

The composition of incremental reimbursement from various state agencies for participation in TennCare/Medicaid programs follows:

	<u>2016</u>	<u>2015</u>
TennCare essential access	\$ 66,150,059	59,654,700
Arkansas UPL/Disproportionate share	2,497,816	2,326,509
Mississippi disproportionate share	5,360,521	5,405,965
Total payments	<u>\$ 74,008,396</u>	<u>67,387,174</u>

The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 and signed into law in February 2009. In the context of the HITECH Act, Regional One Health must implement a certified Electronic Health Record (EHR) in an effort to promote the adoption and “meaningful use” of health information technology (HIT). The HITECH Act includes significant monetary incentives and payment penalties meant to encourage the adoption of EHR technology. Regional One Health received approximately \$1,792,000 and \$391,000 of incentive payments related to EHR implementation for the years ended June 30, 2016 and 2015, respectively. These amounts are included in net patient service revenue within the statements of revenues, expenses, and change in net position.

(11) Charity Care

Regional One Health maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. Charges foregone, based on established rates, were approximately \$291,300,000 and \$283,700,000 in 2016 and 2015, respectively. Included in the charges foregone is the upfront discount applied to all uninsured patients of approximately \$140,000,000 and \$98,300,000 in 2016 and 2015, respectively, as Regional One Health does not pursue collection on these amounts. Regional One Health’s estimated cost of caring for charity care patients for the years ended June 30, 2016 and 2015, was approximately \$88,300,000 and \$82,600,000, respectively.

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(12) Retirement Plans

(a) Defined Benefit Plan

Regional One Health contributes to the Shelby County Retirement System (the Retirement System), a cost-sharing single-employer defined benefit public employee retirement system (PERS) established by Shelby County, Tennessee. The Retirement System is administered by a board, the majority of whose members are nominated by the Shelby County Mayor, subject to approval by the Shelby County Board of Commissioners. The Retirement System issues a publicly available financial report that includes financial statements and required supplementary information. That report may be obtained by writing to the Shelby County Retirement System, Suite 950, 160 North Main, Memphis, Tennessee 38103 or by calling 901-545-3570.

Shelby County provides office space and certain administrative services at no cost to the Retirement System. All other costs to administer the plan are paid from plan earnings.

The Retirement System consists of three plans (Plans A, B, and C). In 1990, Plans A and B were merged into one reporting entity, whereby total combined assets of the merged plans are available for payment of benefits to participants of either of the two previously existing plans. In 2005, Plan C was added and merged with Plans A and B for funding purposes. While the plans were merged, the Retirement System has retained the membership criteria of the previous plans, which are as follows:

- Plan C, a contributory cost-sharing multiple-employer defined benefit pension plan for employees who are also eligible for Plan A,
- Plan B, a contributory cost-sharing multiple-employer defined benefit pension plan for employees hired prior to December 1, 1978, and
- Plan A, a contributory cost-sharing multiple-employer defined benefit pension plan for employees hired on or after December 1, 1978, and those employees that elected to transfer to Plan A from Plan B before January 1, 1981. Plan A was noncontributory for all years prior to 2013.

The Shelby County Board of Commissioners establishes the Retirement System's benefit provisions. Regional One Health pays the established contribution rate to the Shelby County Pension Plan with the employee contribution being withheld from employee pay and Regional One Health paying the employer contribution rate. Regional One Health has no further obligation once the employee leaves Regional One Health. The Retirement System provides retirement, as well as survivor and disability defined benefits.

The Retirement System's funding policy for employee contribution requirements is established by the Board of Administration of the Retirement System. The Shelby County Board of Commissioners establishes the Retirement System's funding policy for employer contribution requirements. For fiscal years 2016, 2015, and 2014, the employer contribution requirements were based on the actuarially determined contribution rates, which were 13.26%, 13.35%, and 13.26%, respectively.

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The actuarially determined contribution rate was calculated using a projected unit credit service pro rata cost method for Plan A, Plan B, and Plan C participants.

For fiscal years 2016, 2015, and 2014, the following contributions were made to the defined benefit plans:

	<u>2016</u>	<u>2015</u>	<u>2014</u>
Regional One Health's contributions:			
Plan A	\$ 168,514	266,282	367,032
Plan B	—	233	2,020
Plan C	39,839	157,330	82,447
Employee contributions:			
Plan A	\$ 15,971	27,224	20,783
Plan B	—	82	709
Plan C	15,259	24,700	23,343

The contributions as a percentage of earned compensation were the same as those for the Retirement System. Regional One Health contributed 100% of its required contributions in 2016, 2015, and 2014.

(b) Defined Contribution Plan

Effective October 1, 2009, Regional One Health established, under the authority of its Board of Directors, The Regional Medical Center at Memphis 403(b) Retirement Plan, a defined contribution pension plan covering employees 21 years of age and older who have completed one year of service. The plan is administered by Regional One Health. The plan provides for a 100% employer match on employee contributions up to 4% of employee compensation. Participants are immediately vested in their contributions plus actual earnings thereon. Participants vest 20% in the employers matching contributions after two years of service, 50% after three years, 75% after four years, and 100% after five years. Forfeitures remain in the plan for the benefit of other participants. Regional One Health contributed approximately \$2,800,000 and \$2,400,000 to the 403(b) plan for the years ended June 30, 2016 and 2015, respectively. 403(b) plan participants contributed approximately \$5,100,000 and \$4,300,000 to the 403(b) plan for the years ended June 30, 2016 and 2015, respectively.

Effective December 1, 2010, Regional One Health established, under the authority of its Board of Directors, The Regional Medical Center at Memphis Nonqualified Supplemental Retirement Plan (Supplemental Retirement Plan). The plan is administered by Regional One Health. The Supplemental Retirement Plan was formed under Section 457(f) of the IRC of 1986, and management believes that it complies with all provisions applicable to a nonqualified deferred compensation plan under IRC Section 409A. Plan participants contributed approximately \$757,000 and \$194,000 to the plan for the years ended June 30, 2016 and 2015, respectively.

(13) Postretirement Benefit Plan

Regional Medical Center Healthcare Benefit Plan (the Plan) is a single-employer defined benefit healthcare plan sponsored and administered by Regional One Health. The Plan provides medical and life insurance

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benefits to eligible retirees and their spouses. Regional One Health's Board of Directors is authorized to establish and amend all provisions. Regional One Health does not issue a publicly available financial report that includes financial statements and required supplementary information for the Plan.

During fiscal year 2010, Regional One Health's Board of Directors approved a plan amendment that eliminated medical coverage for those employees who did not have 15 years of service as of December 31, 2009 and eliminated life insurance coverage for those employees retiring January 1, 2010 or later.

Per GASB Statement No. 45, *Accounting and Financial Reporting Employers for Postemployment Benefits Other Than Pensions*, for financial reporting purposes an actuarial valuation is required at least biennially for postretirement benefit plans with a total membership of 200 or more. Regional One Health's postretirement benefit plan had approximately 308 members as of the last actuarial valuation of June 30, 2016.

(a) Funding Policy

The contribution requirements of employees and the Plan are established and may be amended by Regional One Health's Board of Directors. Monthly contributions are required by retirees who are eligible for coverage. Regional One Health pays for costs in excess of required retiree contributions. These contributions are assumed to increase based on future medical plan cost increases. For fiscal 2016 and 2015, Regional One Health contributed approximately \$959,000 and \$1,181,000, respectively, net of retiree contributions, to the Plan. Plan members receiving benefits contributed approximately \$154,000 in fiscal 2016 and \$233,000 in fiscal 2015 through their required contributions. The following table summarizes the monthly contribution rates for the year beginning July 1, 2015:

	<u>Retiree</u>	<u>Spouse</u>
Pre-Medicare	\$ 2,004	2,244
Pre-Medicare eligible	708	1,668

(b) Annual OPEB Cost and Net OPEB Obligation

Regional One Health's annual other postemployment benefit (OPEB) cost is calculated based on the annual required contribution of the employer (ARC), an amount actuarially determined in accordance with the parameters of GASB Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities (or funding excess) over a period of 30 years. The following table shows the components of

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Regional One Health's annual OPEB cost for fiscal 2016, the amounts actually contributed to the Plan, and changes in Regional One Health's net OPEB obligation:

	<u>2016</u>	<u>2015*</u>
Annual required contributions and annual OPEB cost	\$ 1,323,070	1,290,462
Contributions made	<u>1,113,070</u>	<u>1,452,462</u>
Increase (decrease) in net OPEB obligation	210,000	(162,000)
Net OPEB obligation, beginning of year	<u>750,000</u>	<u>912,000</u>
Net OPEB obligation, end of year	<u><u>\$ 960,000</u></u>	<u><u>750,000</u></u>

(c) Three-Year Trend Information

<u>Fiscal year ended</u>	<u>Annual OPEB cost</u>	<u>Percentage of annual OPEB cost contributed</u>	<u>Net OPEB obligation</u>
June 30, 2016	\$ 1,323,070	79.0%	\$ 918,679
June 30, 2015	1,350,954	107.5	646,672
June 30, 2014	1,297,799	114.6	748,180

* Regional One Health did not obtain an actuarial evaluation of the postemployment benefit plan, as allowed by relevant accounting literature, for the year ended June 30, 2015, so the results reported above are related to the June 30, 2014 valuation.

(d) Funded Status and Funding Progress – Required Supplementary Information

As of July 1, 2015, the Plan was not funded. The actuarial accrued liability for benefits was \$19,271,148 resulting in an unfunded actuarial accrued liability (UAAL) of \$19,271,148.

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Amounts determined regarding the funded status of the Plan and the annual required contributions of the employer are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress, as presented below as required supplementary information, presents multiyear trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

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(e) Schedule of Funding Progress – Required Supplementary Information

Analysis of the Plan's funding status follows:

Actuarial valuation date*	Actuarial value of plan assets	Actuarial accrued liability (AAL)	Plan assets less than AAL	Funded ratio	Covered payroll	AAL as of a percentage of covered payroll
July 1, 2013	\$ —	20,050,142	20,050,142	—	\$ 18,116,596	111.0
July 1, 2014	—	20,050,142	20,050,142	—	18,116,596	111.0
July 1, 2015	—	19,271,148	19,271,148	—	18,693,833	109.0

* All inputs for valuation is provided as of beginning of the fiscal year being actuarially valued.

(f) Actuarial Methods and Assumptions

Projections of benefits for financial reporting purposes are based on the substantive plan (the Plan as understood by the employer and the plan members) and include the types of benefits provided at the time of each valuation and the historical pattern sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

In the July 1, 2015 actuarial valuation, the projected unit credit actuarial method was used. The actuarial assumptions included a 3% investment rate of return, which is a long-term rate of return on general account assets, and an annual inflation rate and annual healthcare cost trend rate of 7.1%, reducing each year until it reaches an annual rate of 4.4% in 2084. The UAAL is being amortized, using a level percentage of pay method, over a 30-year period under the Projected Unit Credit Method.

(14) Transactions with University of Tennessee Center for Health Services

Regional One Health contracts with University of Tennessee Center for Health Services (UTCHS) and University of Tennessee Medical Group (UTMG) to provide, among other things, Regional One Health's house staff, professional supervision of certain ancillary departments, and professional care for indigent patients. Regional One Health also provides its facilities as a teaching hospital for UTCHS.

Operating expenses include approximately \$21,600,000 and \$26,100,000 for the years ended June 30, 2016 and 2015, respectively, for all professional and other services provided by UTCHS/UTMG.

On October 1, 2014, Regional One Health and the University of Tennessee Health Science Center created a jointly governed physician's group known as the University of Tennessee Regional One Physicians (UTROP). The UTROP physician group will replace the existing relationship between Regional One Health and UTMG, and will provide Regional One Health's professional supervision of certain ancillary departments and professional care for patients. Under the UTROP professional services agreement, UTROP assigns all physician revenue to Regional One Health for a fixed contracted fee based on the number of physicians needed to operate the hospital. Regional One Health records the patient service revenue earned by these physicians as gross patient service revenue and is at risk for the collection of these amounts. The fixed fee amount paid by Regional One Health to UTROP during the 2016 and 2015 years was approximately

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\$51,300,000 and \$35,600,000, respectively, and is included in purchased medical services on the statements of revenues, expenses, and changes in net position.

(15) Risk Management

Regional One Health has a self-insurance program for professional and general liability risks, both with respect to claims incurred after the effective date of the program and claims incurred but not reported prior to that date. Regional One Health has not acquired any excess coverage for its self-insurance because Regional One Health is afforded sovereign immunity in accordance with applicable statutes. Presently, sovereign immunity limits losses to \$300,000 per claim. Regional One Health has recorded an accrual for self-insurance losses totaling approximately \$4,200,000 and \$6,800,000 at June 30, 2016 and 2015, respectively.

Incurred losses identified through Regional One Health's incident reporting system and incurred but not reported losses are accrued based on estimates that incorporate Regional One Health's current inventory of reported claims and historical experience, as well as considerations such as the nature of each claim or incident, relevant trend factors, and advice from consulting actuaries.

The following is a summary of changes in Regional One Health's self-insurance liability for professional and general liability costs for fiscal 2016 and 2015:

	<u>2016</u>	<u>2015</u>
Balance at July 1	\$ 6,830,000	7,152,000
Provision for claims reported and claims incurred but not reported	(1,777,112)	179,580
Claims paid	<u>(826,888)</u>	<u>(501,580)</u>
	4,226,000	6,830,000
Amounts classified as accrued expenses and other current liabilities	<u>(1,800,000)</u>	<u>(2,300,000)</u>
Balance at June 30	<u><u>\$ 2,426,000</u></u>	<u><u>4,530,000</u></u>

Like many other businesses, Regional One Health is exposed to various risks of loss related to theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; and natural disasters. Commercial insurance coverage is purchased for claims arising from such matters. Claims settled through June 30, 2016 have not exceeded this commercial coverage in any of the three preceding years.

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The following is a summary of changes in Regional One Health's self-insurance liability for employee health coverage (included in accrued expenses and other current liabilities in the accompanying balance sheets) for fiscal 2016 and 2015:

	<u>2016</u>	<u>2015</u>
Balance at July 1	\$ 2,715,000	1,826,000
Claims reported and claims incurred but not reported	18,433,806	16,024,010
Claims paid	<u>(18,340,806)</u>	<u>(15,135,010)</u>
Balance at June 30	<u>\$ 2,808,000</u>	<u>2,715,000</u>

(16) Commitments

Regional One Health has outstanding service contracts for management services, equipment maintenance, and blood supply services. Estimated future payments under the contracts follow:

2017	\$ 3,712,864
2018	2,862,018
2019	2,415,295
2020	2,172,756
2021	1,519,940
Thereafter	<u>1,294,327</u>
	<u>\$ 13,977,200</u>

Expense under these contracts and other contracts was approximately \$13,700,000 and \$11,800,000 for the years ended June 30, 2016 and 2015, respectively.

(17) Leases

Regional One Health has entered into noncancelable operating leases for certain buildings and equipment. Rental expense for all operating leases was approximately \$5,300,000 and \$5,200,000 for the years ended June 30, 2016 and 2015, respectively. The future minimum payments under noncancelable operating leases as of June 30, 2016 follow:

2017	\$ 5,301,607
2018	4,725,940
2019	2,147,698
2020	1,756,670
2021	1,456,202
Thereafter	<u>8,046,932</u>
	<u>\$ 23,435,049</u>

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(18) Healthcare Industry Environment

Management at Regional One Health continually monitors economic conditions closely, both with respect to potential impacts on the healthcare provider industry and from a more general business perspective. Management recognizes that economic conditions may continue to impact Regional One Health in a number of ways, including uncertainties associated with U.S. healthcare system reform and rising self-pay and emerging high-deductible plan funded patient volumes coupled with increases in uncompensated care and decreasing reimbursement rates relative to governmental payors.

Schedule 1

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Net Position

June 30, 2016

Assets	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Assets:			
Cash and cash equivalents	\$ 16,657,356	52,694	16,710,050
Investments	111,841,180	—	111,841,180
Patient accounts receivable, net	64,422,437	—	64,422,437
Other receivables	13,662,415	149,000	13,811,415
Other current assets	6,432,834	849,337	7,282,171
Total current assets	213,016,222	1,051,031	214,067,253
Restricted cash	—	437,060	437,060
Restricted investments	6,062,721	—	6,062,721
Equity investments	12,980,671	—	12,980,671
Notes receivable	19,221,600	—	19,221,600
Capital assets, net	50,401,613	40,587,300	90,988,913
Total assets	\$ 301,682,827	42,075,391	343,758,218
Liabilities and Net Position			
Liabilities:			
Accounts payable	\$ 14,452,736	—	14,452,736
Accrued expenses and other current liabilities	44,379,028	148,822	44,527,850
Total current liabilities	58,831,764	148,822	58,980,586
Accrued professional and general liability costs	2,426,000	—	2,426,000
Obligation under reverse repurchase agreement	11,893,738	—	11,893,738
Net postemployment benefit obligation	960,000	—	960,000
Notes payable	—	26,550,000	26,550,000
Total liabilities	74,111,502	26,698,822	100,810,324
Net position:			
Invested in capital assets	50,401,613	14,037,300	64,438,913
Restricted for:			
Capital assets	1,896,509	—	1,896,509
Indigent care	702,167	—	702,167
Notes payable	—	437,060	437,060
Unrestricted	174,571,036	902,209	175,473,245
Total net position	227,571,325	15,376,569	242,947,894
Total liabilities and net position	\$ 301,682,827	42,075,391	343,758,218

See accompanying independent auditors' report.

Schedule 2

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Net Position

June 30, 2015

Assets	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Assets:			
Cash and cash equivalents	\$ 9,716,806	47,353	9,764,159
Investments	109,959,639	—	109,959,639
Patient accounts receivable, net	68,627,756	—	68,627,756
Other receivables	10,819,415	149,000	10,968,415
Other current assets	5,983,237	1,052,482	7,035,719
Total current assets	205,106,853	1,248,835	206,355,688
Restricted cash	—	514,785	514,785
Restricted investments	6,901,313	—	6,901,313
Equity investments	10,999,876	—	10,999,876
Notes receivable	19,221,600	—	19,221,600
Capital assets, net	56,687,502	39,319,663	96,007,165
Total assets	<u>\$ 298,917,144</u>	<u>41,083,283</u>	<u>340,000,427</u>
Liabilities and Net Position			
Liabilities:			
Accounts payable	\$ 14,092,765	—	14,092,765
Accrued expenses and other current liabilities	38,169,476	148,200	38,317,676
Total current liabilities	52,262,241	148,200	52,410,441
Accrued professional and general liability costs	4,530,000	—	4,530,000
Net postemployment benefit obligation	750,000	—	750,000
Notes payable	—	26,550,000	26,550,000
Total liabilities	<u>57,542,241</u>	<u>26,698,200</u>	<u>84,240,441</u>
Net position:			
Invested in capital assets	56,687,802	12,769,663	69,457,465
Restricted for:			
Capital assets	2,855,282	—	2,855,282
Indigent care	834,684	—	834,684
Notes payable	—	514,785	514,785
Unrestricted	180,997,435	1,100,635	182,098,070
Total net position	<u>241,375,203</u>	<u>14,385,083</u>	<u>255,760,286</u>
Total liabilities and net position	<u>\$ 298,917,444</u>	<u>41,083,283</u>	<u>340,000,727</u>

See accompanying independent auditors' report.

Schedule 3

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Revenues, Expenses, and Changes in Net Position

Year ended June 30, 2016

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Operating revenues:			
Net patient service revenue	\$ 362,356,166	—	362,356,166
Other revenue	33,033,773	298,000	33,331,773
Total operating revenues	395,389,939	298,000	395,687,939
Operating expenses:			
Salaries and benefits	191,513,277	—	191,513,277
Supplies and services	93,353,541	—	93,353,541
Physician and professional fees	26,080,862	—	26,080,862
Purchased medical services	56,015,982	—	56,015,982
Plant operations	14,630,265	—	14,630,265
Insurance	422,542	—	422,542
Administrative and general	38,619,647	308,651	38,928,298
Community services	933,161	—	933,161
Depreciation	13,425,927	5,146,002	18,571,929
Total operating expenses	434,995,204	5,454,653	440,449,857
Operating loss	(39,605,265)	(5,156,653)	(44,761,918)
Nonoperating revenues (expenses):			
Interest expense	(132,398)	(265,500)	(397,898)
Investment income (loss)	3,066,749	—	3,066,749
Appropriations from Shelby County	27,408,000	—	27,408,000
Other	1,872,675	—	1,872,675
Transfers in (out)	(6,413,639)	6,413,639	—
Total nonoperating revenues (expenses), net	25,801,387	6,148,139	31,949,526
(Decrease) increase in net position	(13,803,878)	991,486	(12,812,392)
Net position, beginning of year	241,375,203	14,385,083	255,760,286
Net position, end of year	\$ 227,571,325	15,376,569	242,947,894

See accompanying independent auditors' report.

Schedule 4

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Revenues, Expenses, and Changes in Net Position

Year ended June 30, 2015

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Operating revenues:			
Net patient service revenue	\$ 347,134,962	—	347,134,962
Other revenue	25,941,916	298,000	26,239,916
Total operating revenues	373,076,878	298,000	373,374,878
Operating expenses:			
Salaries and benefits	179,221,725	—	179,221,725
Supplies and services	84,128,275	—	84,128,275
Physician and professional fees	25,475,185	—	25,475,185
Purchased medical services	44,448,420	—	44,448,420
Plant operations	13,783,854	—	13,783,854
Insurance	2,843,248	—	2,843,248
Administrative and general	34,498,576	247,462	34,746,038
Community services	757,581	—	757,581
Depreciation	13,527,554	4,677,433	18,204,987
Total operating expenses	398,684,418	4,924,895	403,609,313
Operating loss	(25,607,540)	(4,626,895)	(30,234,435)
Nonoperating revenues (expenses):			
Interest expense	(82,291)	(265,500)	(347,791)
Investment income	3,578,035	—	3,578,035
Appropriations from Shelby County	26,816,000	—	26,816,000
Other	8,729,084	1,075	8,730,159
Transfers in (out)	(3,869,244)	3,869,244	—
Total nonoperating revenues (expenses), net	35,171,584	3,604,819	38,776,403
Increase (decrease) in net position	9,564,044	(1,022,076)	8,541,968
Net position, beginning of year	231,811,159	15,407,159	247,218,318
Net position, end of year	\$ 241,375,203	14,385,083	255,760,286

See accompanying independent auditors' report.

Schedule 5

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Cash Flows

Year ended June 30, 2016

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Cash flows from operating activities:			
Receipts from and on behalf of patients and third-party payors	\$ 367,284,642	—	367,284,642
Other cash receipts	32,914,527	298,000	33,212,527
Payments to suppliers	(232,214,752)	(104,884)	(232,319,636)
Payments to employees and related benefits	(186,503,501)	—	(186,503,501)
Net cash (used in) provided by operating activities	(18,519,084)	193,116	(18,325,968)
Cash flows from noncapital financing activity:			
Appropriations received from Shelby County	25,328,013	—	25,328,013
Net cash provided by noncapital financing activity	25,328,013	—	25,328,013
Cash flows from capital and related financing activities:			
Capital expenditures	(13,661,497)	—	(13,661,497)
Interest payments	(124,420)	(265,500)	(389,920)
Net cash used in capital and related financing activities	(13,785,917)	(265,500)	(14,051,417)
Cash flows from investing activities:			
Purchases of investments	(300,665,214)	—	(300,665,214)
Proceeds from sale of investments	312,242,913	—	312,242,913
Investment income proceeds	2,339,839	—	2,339,839
Net cash provided by investing activities	13,917,538	—	13,917,538
Net increase (decrease) in cash and cash equivalents	6,940,550	(72,384)	6,868,166
Cash and cash equivalents, beginning of year	9,716,806	562,138	10,278,944
Cash and cash equivalents, end of year	\$ 16,657,356	489,754	17,147,110

See accompanying independent auditors' report.

Schedule 6

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Cash Flows

Year ended June 30, 2015

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Cash flows from operating activities:			
Receipts from and on behalf of patients and third-party payors	\$ 335,009,290	—	335,009,290
Other cash receipts	25,309,908	298,003	25,607,911
Payments to suppliers	(208,262,648)	(49,950)	(208,312,598)
Payments to employees and related benefits	(180,016,276)	—	(180,016,276)
Net cash (used in) provided by operating activities	(27,959,726)	248,053	(27,711,673)
Cash flows from noncapital financing activity:			
Appropriations received from Shelby County	26,816,000	—	26,816,000
Net cash provided by noncapital financing activity	26,816,000	—	26,816,000
Cash flows from capital and related financing activities:			
Capital expenditures	(11,893,966)	—	(11,893,966)
Proceeds from pledges	22,169	—	22,169
Proceeds from sale of capital assets	31,398	—	31,398
Interest payments	(82,291)	(269,625)	(351,916)
Net cash used in capital and related financing activities	(11,922,690)	(269,625)	(12,192,315)
Cash flows from investing activities:			
Purchases of investments	(238,329,755)	—	(238,329,755)
Proceeds from sale of investments	249,085,424	—	249,085,424
Investment in equity investees	(1,300,000)	—	(1,300,000)
Investment income proceeds	3,345,720	—	3,345,720
Net cash provided by investing activities	12,801,389	—	12,801,389
Net decrease in cash and cash equivalents	(265,027)	(21,572)	(286,599)
Cash and cash equivalents, beginning of year	9,981,833	583,710	10,565,543
Cash and cash equivalents, end of year	\$ 9,716,806	562,138	10,278,944

See accompanying independent auditors' report.

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Roster of Management Officials and Board Members

June 30, 2016

(Unaudited)

Management Officials

Reginald Coopwood, M.D., President and CEO

Eric Benink, M.D., Senior Vice President/Chief Medical Officer

Pam Castleman, MSN, Senior Vice President/Chief Nursing Officer

Sarah Colley, Senior Vice President

Susan Cooper, RN, MSN, FAAN, Senior Vice President/Chief Integration Officer

Jackie Lucas, FACHE, Senior Vice President/CIO

Tammie Ritchey, CFRE, Vice President of Development/Foundation Executive Director

Robert Sumter, Ph.D., Executive Vice President/COO

Tish Towns, FACHE, Senior Vice President, External Relations

Rick Wagers, MBA, Senior Executive Vice President/CFO

Monica Wharton, ESQ, Senior Vice President/Chief Legal Counsel

Board Members

Ken Brown, Ph.D.

Pam Brown

Tyrone Burroughs

Ronald Coleman

Judy Edge

William D. Evans, Pharm.D.

James Freeman, M.D.

Brenda Hardy, M.D.

Edith Kelly-Green

Scot Lenoir

Scott McCormick

Commissioner Reginald Milton

David Popwell

Phil Shannon

John Vergos

See accompanying independent auditors' report.

Attachment B.EconomicFeasibility.F.1

Regional One Health - Extended Care Hospital

Statement of Revenue and Expenses

June 30, 2017

(\$ in Thousands)

Month of June			Twelve Months Ending June 30		
	2017 Actual	2017 Budget		2016-17 Actual	2016-17 Budget
1			Patient Service Revenue		
2	\$ 5,324	\$ 4,922	Inpatient Revenue	\$ 62,710	\$ 59,171
3	-	-	Outpatient Revenue	-	-
4	<u>\$ 5,324</u>	<u>\$ 4,922</u>	Gross Patient Service Revenue	<u>\$ 62,710</u>	<u>\$ 59,171</u>
5			Deductions from Revenue		
6	\$ 3,172	\$ 3,595	Contractual Adjustments	\$ 48,430	\$ 43,220
7	397	24	Charity Care	280	294
8	466	123	Provision for Bad Debts	599	1,479
6	<u>\$ 4,035</u>	<u>\$ 3,742</u>	Total Deductions from Revenue	<u>\$ 49,309</u>	<u>\$ 44,993</u>
7	<u>\$ 1,289</u>	<u>\$ 1,180</u>	Net Patient Revenue	<u>\$ 13,401</u>	<u>\$ 14,178</u>
8	<u>\$ -</u>	<u>\$ -</u>	Other Operating Revenue	<u>\$ -</u>	<u>\$ -</u>
9	<u>\$ 1,289</u>	<u>\$ 1,180</u>	Net Revenue	<u>\$ 13,401</u>	<u>\$ 14,178</u>
8			Operating Expenses		
9	\$ 511	\$ 481	Salary Expense	\$ 5,875	\$ 5,873
10	109	107	Employee Benefits	1,019	1,288
11	210	183	Supplies	1,966	2,206
12	281	237	Other Expenses	2,720	2,842
13	20	14	Operation of Plant	238	166
14	86	72	Lease Expense	948	870
15	<u>\$ 1,217</u>	<u>\$ 1,094</u>	Total Operating Expenses	<u>\$ 12,767</u>	<u>\$ 13,244</u>
16	<u>\$ 72</u>	<u>\$ 86</u>	Net Income	<u>\$ 634</u>	<u>\$ 934</u>
			Volume		
17	607	630	Inpatient Days	7,378	7,574
18	16	21	Inpatient Discharges	192	255
19	37.9	30.0	Average Length of Stay	38.4	29.7
			Operational Indicators		
20	\$ 8,771	\$ 7,813	Gross Patient Revenue per Pat Day	\$ 8,500	\$ 7,812
21	\$ 2,124	\$ 1,873	Net Patient Revenue per Pat Day	\$ 1,816	\$ 1,872
22	\$ 2,004	\$ 1,737	Total Operating Exp per Pat Day	\$ 1,730	\$ 1,749
23	\$ 1,022	\$ 933	Salaries,Wages,Benefits per Pat Day	\$ 934	\$ 945
24	\$ 346	\$ 290	Supplies per Pat Day	\$ 267	\$ 291
25	\$ 636	\$ 513	Other Expenses per Pat Day	\$ 529	\$ 512
26	\$ 332,749	\$ 234,381	Gross Patient Revenue per Discharge	\$ 326,614	\$ 232,043
27	\$ 80,561	\$ 56,190	Net Patient Revenue per Discharge	\$ 69,798	\$ 55,599
28	\$ 76,043	\$ 52,095	Total Operating Exp per Discharge	\$ 66,493	\$ 51,937
29	\$ 38,774	\$ 28,000	Salaries,Wages,Benefits per Discharge	\$ 35,910	\$ 28,082
30	\$ 13,123	\$ 8,714	Supplies per Discharge	\$ 10,242	\$ 8,649
31	\$ 24,145	\$ 15,381	Other Expenses per Discharge	\$ 20,342	\$ 15,205

Regional One Health - Extended Care Hospital

Balance Sheet

June 30, 2017

(\$ in Thousands)

Assets		June 2017
Current Assets:		
1 Cash and Cash Equivalents	\$	4,680
2 Investments, market value		-
3 Cash and Investments, net of Board Designated		4,680
4 Patient Accounts Receivable-LTACH		17,092
5 Less Allowances for Contractual & Uncompensated Care-LTACH		(8,999)
6 Patient Accounts Receivable, net-LTACH		8,093
7 Other Accounts Receivable		-
8 Due from Affiliates		-
9 Prepaid Expenses		61
10 Total Current Assets		12,834
11 Total Assets	\$	12,834
Liabilities & Fund Balance		
Current Liabilities:		
12 Accounts Payable	\$	378
13 Accrued Expenses		408
14 Compensated Absences		202
15 Deferred Revenue		-
16 Total Current Liabilities		988
Fund Balance:		
17 Revenue over (under) Expenses, Current Year		634
18 Unrestricted Fund Balance		11,212
19 Total Liabilities & Fund Balance	\$	12,834

Regional One Health - Extended Care Hospital
Statement of Revenue and Expenses
June 30, 2017
(\$ in Thousands)

<u>Month of June</u>			<u>Twelve Months Ending June 30</u>		
	<u>2017 Actual</u>	<u>2017 Budget</u>		<u>2016-17 Actual</u>	<u>2016-17 Budget</u>
1			<u>Patient Service Revenue</u>		
2	\$ 5,324	\$ 4,922	Inpatient Revenue	\$ 62,710	\$ 59,171
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5			<u>Deductions from Revenue</u>		
6	\$ 3,172	\$ 3,595	Contractual Adjustments	\$ 48,430	\$ 43,220
7	397	24	Charity Care	280	294
8	466	123	Provision for Bad Debts	599	1,479
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8	<u>\$ -</u>	<u>\$ -</u>	<u>Other Operating Revenue</u>	<u>\$ -</u>	<u>\$ -</u>
9	<u>\$ 1,289</u>	<u>\$ 1,180</u>	Net Revenue	<u>\$ 13,401</u>	<u>\$ 14,178</u>
8			<u>Operating Expenses</u>		
9	\$ 511	\$ 481	Salary Expense	\$ 5,875	\$ 5,873
10	109	107	Employee Benefits	1,019	1,288
11	210	183	Supplies	1,966	2,206
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16	<u>\$ 72</u>	<u>\$ 86</u>	Net Income	<u>\$ 634</u>	<u>\$ 934</u>
			<u>Volume</u>		
17	607	630	Inpatient Days	7,378	7,574
18	16	21	Inpatient Discharges	192	255
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			<u>Operational Indicators</u>		
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31	\$ 24,145	\$ 15,381	Other Expenses per Discharge	\$ 20,342	\$ 15,205

8500021350

AGREEMENT FOR THE PROVISION OF GRADUATE MEDICAL EDUCATION
AT THE REGIONAL MEDICAL CENTER AT MEMPHIS

THIS AGREEMENT is made and entered into this 1st day of July, 2011, by and between the University of Tennessee and its College of Medicine (the "UNIVERSITY"), and The Shelby County Health Care Corporation d/b/a Regional Medical Center at Memphis ("The MED").

WITNESSETH

WHEREAS, the parties have operated under a master contract governing the provision of graduate medical education ("GME") at The MED for many years; and

WHEREAS, the UNIVERSITY'S educational programs are intended to provide Students and Residents with a variety of structured learning experiences, including the participation in patient care activities;

WHEREAS, the parties acknowledge the fact that high quality medical care for patients in a hospital setting is often associated with the participation of medical students and residents participating in accredited GME programs;

WHEREAS, both the UNIVERSITY and The MED will benefit from the participation of Students and Residents providing patient care at The MED under appropriate supervision from UNIVERSITY faculty physicians;

WHEREAS, the UNIVERSITY acknowledges the importance of The MED with respect to its overall GME Programs and intends to provide The MED with a decision making role in its consortium commensurate with The MED's importance as set forth in this agreement;

NOW, THEREFORE, in consideration of the mutual agreement and covenants of the parties and for other good valuable consideration, the parties agree as follows:

I. GENERAL INFORMATION-It is understood and agreed that:

- A. The term "Resident" shall include House Staff, House Officers, and Fellows participating under the auspices of the University in a GME program approved or recognized by the Accreditation Council on Graduate Medical Education ("ACGME"). "Resident" shall include House Staff, House Officers, and Fellows participating under the auspices of the University in the Burn Fellowship or in Oral Surgery. The term "Student" shall refer to a person enrolled as an undergraduate in the College of Medicine.
- B. It is understood by both parties that Students and Residents subject to this Agreement, while participating to any extent in patient care activities, will be permitted access to The MED premises for the exclusive purpose of medical training by the UNIVERSITY, as an adjunct to the patient care activities taking

- place at the MED and its facilities and are not, by virtue of such actions, considered employees, agents, or servants of The MED for any purpose.
- C. The UNIVERSITY is responsible for the control and supervision of the Students and Residents and acknowledges sole responsibility for directing all aspects of their medical education.
 - D. Throughout the term of this Agreement, Residents are employees of The State of Tennessee, of which the University is a part. Resident's salary and benefits are provided and paid by The UNIVERSITY or the State, although they will be reimbursed as provided herein below by The MED.
- The UNIVERSITY Residents are covered as State employees under the provisions of the Tennessee Claims Commission Act (1985). Evidence of current malpractice coverage reflecting inclusive dates and limitations, if any, will be provided to The MED upon request.

II. TERMS OF PERFORMANCE

A. Resident Services

1. Staffing and Supervision.

- a. The UNIVERSITY agrees to provide The MED with a house staff of GME Residents in accordance with the staffing levels and departmental distribution specified in Exhibit B. House staff, including all persons enrolled in GME programs through the UNIVERSITY, shall be referred to in this Agreement as "Residents." The UNIVERSITY shall be solely responsible for recruiting, designating, assigning and training Residents at The MED. The average number and general distribution of Residents assigned to The MED shall be negotiated annually by the Associate Dean for GME and the Chief Medical Officer as Exhibit B and shall be determined no later than May 1 for the academic year which begins the following July. Periodic review shall be at least quarterly or at the request of the Chief Medical Officer at The MED. The numbers last in effect will not be changed in subsequent years without the express agreement of The MED and the UNIVERSITY. In participating in the designation of number and distribution of Residents as set forth in this Paragraph The MED assumes no responsibility for the recruitment or training of the Residents, which shall remain the sole responsibility of the UNIVERSITY.
- b. The UNIVERSITY shall provide or make arrangements for designating attending physicians, all of whom shall be faculty members of the UNIVERSITY, for general supervision, and direction of all Residents and Students at The MED, consistent with the applicable guidelines developed by State and Federal laws and/or accrediting agencies. Such supervision shall be as directed by the UTGME Supervision Policy as attached (Exhibit C). The number of faculty attending physicians shall be based upon an

established ratio of faculty to housestaff for the particular department as set forth in Exhibit B.

- c. In all cases the GME supervision ratio of faculty at The MED shall not be less than one faculty member per four residents.
- d. Patient care and treatment shall be provided by Residents only under the supervision and direction of attending physician Faculty. Nothing in this Agreement shall be construed as assigning Residents to act on behalf of or under the direction of The MED.

B. Training Program.

- 1. Medical Staff Membership. Faculty shall be members of Medical Staff and subject to, and bound by, all applicable medical staff and Hospital policies of The MED. The UNIVERSITY shall be responsible for notifying its personnel of The MED's policies applicable to their job responsibilities and shall cooperate with The MED's training programs designed to instruct staff regarding The MED's policies.
- 2. Faculty Appointments. The MED's medical staff members must be appointed to the faculty of the UNIVERSITY College of Medicine in order to be on the Training Program teaching staff at The MED. Any faculty appointments shall be made by the UNIVERSITY College of Medicine in accordance with its established policies.
- 3. Cost of Resident Service. The UNIVERSITY shall pay for or provide all resident salaries, health benefits, workers compensation benefits, applicable taxes and all other reemployment related benefits or expenses.
- 4. MED Payment of Resident Costs. The UNIVERSITY shall bill The MED for Resident costs on a monthly basis in accordance with the provisions of Paragraph II. D. 9. This payment and all funds provided to the University under this Agreement are for the exclusive purpose of providing GME.
- 5. Accreditation of Teaching Program. The UNIVERSITY is responsible for maintaining accreditation of medical education and training programs implemented (in whole or in part) at The MED. The MED shall cooperate with and assist the UNIVERSITY in maintaining such accreditation, as provided for in this Agreement.
- 6. Documentation. The UNIVERSITY agrees to provide such documentation as is reasonably required by The MED to verify support of GME residents and Faculty. The methodology utilized by the UNIVERSITY is subject to the approval of The MED.

C. Research

The MED recognizes and agrees that, as a part of its role as a teaching hospital, it will be the location of research projects involving both inpatients and outpatients. The MED agrees to make its patients available for such research and to make its staff and equipment available to support such research under the condition that any research grant application undertaken by UNIVERSITY which requires participation in, or contribution to, patient access, space availability or other MED resource allocation, will be submitted to The MED'S CMO for approval. This function will be carried out concurrently with IRB review and shall not

delay submission of the application to the outside agency. The parties further agree that UNIVERSITY will include in its Research Grant proposals expenses which The MED would incur for use of staff, equipment and facilities if the study is conducted at The MED. The University will advise The MED of Grants awarded. University will reimburse The MED for expenses incurred for laboratory tests, radiological studies, and all other procedures required by study protocols or contracts at a mutually agreed rate. Unless otherwise agreed to, clinical research studies conducted by the UNIVERSITY at The MED are governed by a Clinical Research Agreement between the parties dated October 22, 2007.

D. The MED.

1. The MED shall, at its own expense, own, maintain and operate the Hospital with qualified and adequate personnel, and provide sufficient supplies, equipment, and facilities in order to maintain a hospital in compliance with the accreditation standards of The Joint Commission ("TJC"), ACGME, and any other applicable accrediting and regulatory bodies, and in conformity with all applicable state and federal laws, rules, regulations and standards.
2. The MED shall cooperate with the UNIVERSITY to maintain teaching or education accreditation standards within their control, and notify the UNIVERSITY within 15 days of such time as The MED has knowledge of matters which may compromise educational program accreditation. Any such notice shall be given in writing, delivered only to the UNIVERSITY's Office of Graduate Medical Education, and shall be handled in such a manner as to preserve such privileges as may be available under applicable law, including but not limited to peer review privilege.
3. The MED shall include UNIVERSITY personnel in training programs regarding medical staff Hospital policies, and shall cooperate with the UNIVERSITY in instructing UNIVERSITY personnel regarding medical staff Hospital policies.
4. The MED will provide the physical facilities and other equipment necessary for the clinical educational experiences of Residents and Students as agreed upon by both parties.
5. The MED will provide opportunities for Residents and Students to have satisfactory training experiences commensurate with the standards for Liaison Committee on Medical Education ("LCME") accredited medical schools and ACGME accredited programs.
6. The MED agrees to provide appropriate call quarters including providing the availability of food for Residents and Faculty supervising physicians on call and agrees to provide parking facilities for Residents, and Faculty supervising physicians assigned to The MED. The MED agrees to take reasonable precautions to provide a safe environment for Residents.
7. The MED shall permit Residents to have (a) access to patients as designated or assigned to them by their supervising Faculty attending

physicians, (b) access to the charts of those patients assigned, and (c) access to and use of clinical information retrieval systems within The MED.

8. The MED through its Chief Medical Officer may suspend patient care responsibilities or otherwise exclude from the Hospital any Resident or Student who fails to adhere to The MED's policies, procedures and quality expectations, subject to final resolution of any such individual's status by The MED and the UNIVERSITY. The UNIVERSITY shall provide replacement services to The MED for any Resident suspended or excluded hereunder, if available. The UNIVERSITY retains the sole right and responsibility for discipline and/or termination of residents.
 9. The MED agrees to compensate the UNIVERSITY on a monthly basis upon receipt of an invoice from UNIVERSITY for the Residents and faculty supervision of Residents in accordance with fixed amounts, set in advance and agreed upon in writing by the parties and attached as an amendment to this Agreement (Exhibits A & B). The fixed amount shall include any compensation of the Residents' salary and benefits and any associated administrative costs mutually agreed upon by the parties (Exhibit A).
 10. The MED shall provide baseline medical treatment and care to any Resident, for any injury incurred on the job, including without limitation, source-patient testing or screening as appropriate, with transfer of the Resident's medical records necessary for such Resident to receive subsequent care through the UNIVERSITY health care benefits program, which shall assume full Workers' Compensation responsibility for any injury related to an occurrence in the work place. The MED is not responsible for medical care for Residents except this first aid.
 11. The MED shall provide certain on-duty benefits to Residents as established by the GME Committee.
- E. The UNIVERSITY
1. The UNIVERSITY shall perform the responsibilities of a LCME accredited College of Medicine. This responsibility includes the exclusive control of the education and evaluation of Students.
 2. The UNIVERSITY shall perform the responsibilities as the institutional sponsor of the Graduate Medical Education Program as described in the "Essentials of Accredited Residencies" published by ACGME. This includes the establishment and maintenance of a Graduate Medical Education Committee ("GMEC") which meets at least quarterly and whose membership shall include representation of the major affiliated institutions, appropriate UNIVERSITY administrators, and peer selected residents. After consultation with each hospital that has a Major Affiliation Agreement with the College of Medicine, the dean of the College of Medicine shall appoint a representative of that hospital to the GME Committee. The GMEC Chair and/or the UNIVERSITY's Designated Institutional Official ("DIO") shall present an annual report to the appropriate committees of the Medical Staff of The MED, reviewing

- the activities of the GMEC as required by the ACGME Institutional Requirements. The GMEC and The appropriate Medical Staff committees of The MED shall have the opportunity to regularly communicate about the patient safety and quality of patient care provided by the Residents.
3. The UNIVERSITY shall centralize records and institutional administrative support for all approved medical education programs in the Office for Academic Affairs for Students and the Office of Graduate Medical Education for Residents. This shall include but not be limited to: a) maintenance of master records of all Residents and Students assigned to The MED, including information necessary for certification, scheduling and rotation; b) payroll and fringe benefits administration; c) the provision of central payroll function for paychecks of all Residents assigned to The MED; and d) monitoring of Resident Agreements and payroll forms.
 4. The UNIVERSITY shall invoice The MED monthly for its pro rata share of Resident costs on a regular basis, including salary, FICA, fringe benefits, and any administrative costs in accordance with Paragraph II. D. 9.
 5. The UNIVERSITY shall establish appropriate policies and procedures to govern GME programs in compliance with ACGME and have these policies available on the GME website for all residents and participating institutions.
 6. The UNIVERSITY shall determine the qualifications for, interview, and accept all Students in the College of Medicine. The UNIVERSITY shall determine the qualification for, recruit, select, and appoint all Residents in the GME program.
 7. In compliance with TJC standards, the UNIVERSITY shall make available on the GME website a listing of all Residents and the procedures that the Resident can perform without supervision. In addition, the UNIVERSITY shall provide adequate communication resources and technological support, at a minimum through computer and internet access for the DIO, GME staff, and personnel, Program Directors, faculty, Residents and The MED.
 8. The UNIVERSITY shall assure compliance with Tennessee Medical Board licensure requirements for Residents.
 9. The UNIVERSITY will assign Residents and Students to The MED on a rotating basis. Such assignments will be made by the Office of Academic Affairs through the individual clerkship directors for students and the respective program directors for Residents.
 10. The UNIVERSITY will remove a Student or Resident from the clinical experiences at The MED at the request of The MED if the Resident's or Student's behavior and conduct are inappropriate. This shall be consistent with the provisions of Paragraph II D.8. of this Agreement.
 11. The UNIVERSITY faculty will be responsible for the supervision and control of Residents and Students at The MED. Faculty members will be responsible for providing supervision according to UNIVERSITY policies

and/or LCME/ACGME, or other appropriate practice specialty guidelines. Faculty members will be responsible for providing attending and consultative services for all unassigned patients of The MED in accordance with the privileges granted to them under the Medical Staff By-Laws.

12. Faculty will supervise the education of Residents and delivery of patient care services associated with GME activities at The MED, serve as attending and consultative physicians in accordance with the Medical Staff Bylaws of The MED, and provide for appropriate documentation of treatment to patients personally or through documentation provided by Residents.
13. The Office of Graduate Medical Education shall report to The MED on a periodic basis the Residency Review Committee accreditation status and the results of an annual or their periodic survey of Residents seeking feedback from Residents as to their satisfaction with the UNIVERSITY's training programs at The MED's facilities.
14. The UNIVERSITY shall assist in preparation of data and scheduling of site visits for accreditation of Training Programs by the ACGME and other official accreditation bodies.
15. The UNIVERSITY shall prepare, on behalf of the Program Director of each Training Program, certificates indicating satisfactory completion by a Resident of training years.

III. COORDINATION OF GME ACTIVITIES

- A. The primary UNIVERSITY representative for the day to day management of this Agreement will be the Associate Dean for GME for Resident issues and the Associate Dean for Academic Affairs for Student issues.
- B. The primary MED representative for the day to day management of this Agreement will be the Chief Medical Officer ("CMO").
- C. Dispute Resolution will be addressed by the Chancellor of the University of Tennessee Health Sciences Center and Chief Executive Officer for The MED and follow the procedure set forth in Paragraph VI. Y. below.
- D. The MED's CMO will monitor Resident rotation schedules monthly to assure compliance with the annual Resident GME budget, rotation assignment plan and UTGME Supervision Guidelines. In conjunction with this review of the rotation schedule assignments, the GME office will track the actual level of faculty physician supervision provided as compared to the level budgeted.
- E. Based upon the above monitoring, if the amount of Resident/faculty supervision services provided is less than the amount budgeted the overpayment will be rebated to The MED. Variances from the established budget will be monitored and reconciliations made on not less than a quarterly basis.

IV. TERM AND TERMINATION

- A. Effective Date. The effective date of this Agreement shall be July 1, 2011.
- B. Term. The term of this Agreement shall be five (5) years, beginning on the effective date of this Agreement and ending June 30, 2016. As ACGME requires

all hospital agreements to be no more than five years old, this Agreement cannot be extended for additional time beyond 2016.

C. Termination.

1. For Convenience. This Agreement may be terminated without cause by any party by the provision of at least 365 days prior written notice to the other parties.
2. Upon Material Change. In the event of a change or changes in the health care regulatory or reimbursement environment which could reasonably be expected to substantially deprive any party of one or more of the material benefits contemplated by this Agreement, then the parties shall, within fifteen (15) calendar days following notice from one party to the other of the occurrence of such a change begin negotiations in good faith to amend this Agreement as necessary to restore the parties to a mutually beneficial relationship under this Agreement. In the event such negotiations fail to produce, within thirty (30) days following the original written notice of the occurrence this Agreement may be terminated by either party upon an additional sixty (60) days written notice to the other party.

V. INDEMNIFICATION

Each party to this Agreement agrees that if it is found to be without direct fault through the acts or omissions of its employees or agents, and is held liable for the acts or omissions of the other party's employees or agents solely arising out of their failure to provide medical care in accordance with the recognized standard of professional practice, its rights of contribution or indemnity as provided by the applicable laws for the State of Tennessee may be pursued in accordance with such laws. Further, each party agrees that the exclusive remedy for claims against the University under this section, if it accepts such jurisdiction, lies in the Tennessee Claims Commission. The liability of The MED (and its obligation to indemnify) is subject to the provisions of the Governmental Tort Liability Act, T.C.A. 29-20-101 et. seq., and nothing in this Agreement shall be considered as extending or expanding the limitations on recovery allowed under actions brought against The MED that would otherwise be covered under that statute.

~~Notwithstanding the foregoing, to the extent any claims are brought against The MED for the acts or omissions of a Resident or Student under this Agreement under any theory of liability, including but not limited to, under the theory of actual or apparent agency, and including as well allegations of negligent supervision, then the University shall hold harmless The MED for such claims, and agrees to reimburse The MED for reasonable attorneys' fees and costs it incurs in defending said claims.~~

VI.

MISCELLANEOUS

A. Confidentiality.

1. Patient Records. The Parties shall maintain the confidentiality of all patient records and shall comply with all applicable federal, state, and local laws and regulations, Hospital and Medical Staff By-Laws, policies, and procedures regarding the confidentiality of medical records.
2. Privileged Information. Each party shall maintain the confidentiality of all information provided by any other party to which legal privilege may



University's liability is governed by Tennessee Claims Commission Act 9-8-301.

apply. Each Party shall disclose privileged information only to personnel under its supervision and only on an as needed basis consistent with applicable law. All personnel of each Party shall be bound by the provisions of this Section, and each Party shall be responsible for informing personnel under its supervision of these requirements, as appropriate. No party shall be in breach of this Section solely by reason of its compliance with federal, state, or local law requiring disclosure of privileged information, provided that prior to any such disclosure such Party shall notify the other Party in writing of its intent to disclose such information, and shall permit the other Party a meaningful opportunity to assert any applicable privilege.

- B. Risk Management and Quality Assurance. The Parties shall cooperate in risk management and quality assurance activities and shall exchange information for risk management and quality assurance purposes. Provided, however, nothing contained herein shall be construed as abrogating the attorney-client privilege or otherwise adversely affect the attorney-client relationship or any quality assurance/peer review activity, and provided further that each party shall take all reasonable steps to preserve any such applicable privilege.
- C. Maintenance of Funding for GME. The Parties will work diligently to maintain Graduate Medical Education funding from state and federal sources. Any state or federal GME funds paid to the UNIVERSITY will be transferred to The MED based on annual negotiations.
- D. Independent Contractor. In the performance of this Agreement, the UNIVERSITY and The MED are at all times acting as independent contractors. No party shall have or exercise control over the specific methods by which the other perform their duties under this Agreement.
- E. Assignment and Subcontracting. This Agreement shall be binding and to the benefit of the Parties and their respective successors and assigns; provided, however that no Party may assign any of its interests, rights or obligations under this Agreement without the prior written consent of the other Party. No Party may subcontract for the performance of any of these duties under this Agreement without the prior written consent of the other Party. This provision shall not limit the right of any Party to engage individuals who may perform services under this Agreement; however each Party shall remain fully responsible for its performance as provided in this Agreement.
- F. No Third Party Beneficiaries. None of the provisions of this Agreement are or shall be construed as for the benefit of or enforceable by any person not a Party to this Agreement.
- G. Modification. This Agreement constitutes the entire agreement of the Parties with respect to its Resident and GME Services, and supersedes all prior agreements, representation, or communication, oral or written, relating thereto. This Agreement may not be modified except by a written amendment properly approved and executed by all Parties.
- H. Waiver. No waiver, express or implied, of any breach of this Agreement shall constitute a waiver of any right under this Agreement or of any subsequent breach, whether of a similar or dissimilar nature.

- I. HIPAA. The MED and the UNIVERSITY shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164 Privacy and Security Laws as may be amended from time to time.
- J. Severability. If any provision of this Agreement shall be unenforceable for any reason, the remaining portions shall remain in force and effect; provided, however, that if the removal of any such provision has the effect of materially altering the obligation of any Party so as to cause serious hardship to such Party or to cause such Party to act in violation of its Articles of Incorporation the party so affected shall have the right to terminate this Agreement upon thirty (30) days written notice to the other Party.
- K. Governing Law. The Agreement shall be governed by the law of the State of Tennessee.
- L. Related Parties and Subcontractor Requirements. Each party shall, upon proper request, allow the United States Department of Health and Human Services, the Comptroller General of the United States, the Tennessee Department of Health, the Tennessee Department of Finance and Administration, and their duly authorized representatives access to this Agreement and to all books, documents, and records necessary to verify the nature and extent of the costs of services provided by any party under this Agreement, at any time during the term of this Agreement and for an additional period of five (5) years following the last date services are furnished under this Agreement. If any party carries out any of its duties under this Agreement through an agreement between its and an individual or organization related to it, that party to this Agreement shall require that a clause be included in such agreement to the effect that until the expiration of five (5) years after the furnishing of services pursuant to such agreement, the related organization shall make available, upon request to the United States Department of Health and Human Services, the Comptroller General of the United States, the Tennessee Department of Health, the Tennessee Department of Finance and Administration, and their duly authorized representatives access to this Agreement and to all books, documents, and records necessary to verify the nature and extent of the costs of services provided by any party under this Agreement.
- M. Equal Opportunity. The parties shall abide, to the extent applicable thereto, by the provisions of Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Sec. 2000e et seq., as amended), which prohibits discrimination against any employee or applicant for employment or recipient of services on the basis of race, religion, color, sex or national origin. The parties further agree to abide by Executive Order No. 11246, as amended, which prohibits discrimination on the basis of sex; the Age Discrimination in Employment Act, 29 U.S.C. Sec. 621 et seq., as amended, and 45 C.F.R. 90, which prohibits discrimination on the basis of age; Section 5045 of the Rehabilitation Act of 1973, 29 U.S.C. Sec. 701 et seq., which prohibits discrimination on the basis of handicap; and the Americans with Disabilities Act, 42 U.S.C. Sec. 12101 et seq., and 29 C.F.R. 1630, which provides that no qualified individual with a disability, by reason of such disability, shall be denied employment, excluded from participation in, or denied the benefits of services, programs or activities.

- N. Binding Effect Upon Successors. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, successors, legal representatives and assigns; provided that this provision shall not be construed as permitting assignment, substitution, delegation or other transfer of rights or obligations except strictly in accordance with the other provisions of this Agreement.
- O. Integration. This Agreement constitutes the entire agreement between the parties pertaining to the subject matter hereof, and supersedes all prior agreements and understandings pertaining thereto. No covenant, representation or condition not expressed in this Agreement shall affect or be deemed to interpret, change or restrict the express provisions hereof unless reduced to writing and signed by both parties.
- P. Exhibits, Etc. All exhibits and other documents attached to or to be delivered in connection with this Agreement are expressly made a part of this Agreement.
- Q. Further Assurances. The parties shall execute and deliver all documents, provide all information and take or forbear from any action that may be reasonably necessary or appropriate to achieve the purposes of this Agreement.
- R. Authorization. Each individual executing this Agreement does thereby represent and warrant to each other person so signing (and to each other entity for which another person may be signing) that he or she has been duly authorized to execute this Agreement in the capacity and for the entity set forth above such person's signature.
- S. Execution by Counterpart. This Agreement may be executed separately or independently by the parties in counterpart, each of which together shall be deemed to have been executed simultaneously and for all purposes to be one instrument.
- T. Force Majeure. Neither party shall incur any liability to the other party, nor shall either party be entitled to terminate this Agreement, if the performance by either party of its obligations under this Agreement is prevented or delayed by act of God, the public enemy, earthquakes, fires, epidemics, civil insurrections, curtailment of or failure to obtain sufficient electrical power, strikes, lockouts or similar unforeseen and unusual circumstances beyond the control and without the fault of such party. Any party claiming any such excuse for non-performance shall use its best efforts to avoid or remove such cause, shall continue performance to the degree possible and as soon as possible, and shall give prompt written notice to the other party of the situation.
- U. Compliance with Applicable Laws. The parties shall comply with all applicable statutes, laws, rules, regulations, licenses, certificates and authorizations of any governmental body or authority in the performance of its obligations under this Agreement. This Agreement shall be subject to amendments to applicable laws and regulations relating to the subject matter hereof, but to the extent that any inconsistency is thereby created, the parties shall use their best efforts to accommodate the terms and intent of this Agreement and of such amendments. Each party shall obtain and maintain current and in force all licenses, certifications, authorizations and permits (and shall pay the fees therefor) required to carry out its obligations under this Agreement.

- V. Notices. Unless otherwise specified in this Agreement, any notice, document, or other communication given, or made hereunder shall be sufficient in writing and shall be deemed given upon (a) hand delivery, (b) transmission by facsimile and oral confirmation of receipt, (c) deposit of the same in the United States registered or certified mail, first class postage and fee prepaid, and correctly addressed to the party for whom it is intended at the following addresses:

If to The MED: Chief Medical Officer
Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

Chief Legal Officer and General Counsel
Regional Medical Center at Memphis
877 Jefferson Avenue
Memphis, TN 38103

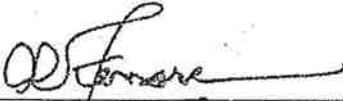
If to the UNIVERSITY: Associate Dean GME
910 Madison Avenue Suite 1031
Memphis, TN 31863

Or at such other place or places as shall from time to time be specified in a notice similarly given. Each Party shall promptly notify the other Parties of any change of address.

- W. Nondiscrimination. The parties hereto agree not to discriminate against any individual on account of race, relation, national origin, or handicap unrelated to the reasonable requirements of this Agreement.
- X. Section Headings. Section Headings are for convenience only and shall not be construed as part of this Agreement.
- Y. Dispute Resolution. Any controversy, dispute, or disagreement arising out of or related to this Agreement or the breach of this Agreement shall be settled in accordance within this provision. In the event a dispute arises between the parties, each party shall be obligated to meet and confer with the other in good faith, on reasonable notice and at a mutually agreeable location. The parties agree that if either party refused to participate in such a conference, or if such a conference fails to produce a mutually acceptable resolution of the dispute within a mutually acceptable time, either party may submit the matter to mediation. Such mediation will occur upon consent of the parties which consent may be withdrawn at any time.
- Z. Compliance. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable state, local and federal law, including the Medicare/Medicaid anti-kickback/Fraud and Abuse provisions and the Stark Law. Notwithstanding any unanticipated effect of any provisions herein, neither party will intentionally conduct itself under the terms of this Agreement in a manner to constitute a violation of said statutes. UNIVERSITY agrees to cooperate fully with compliance efforts of THE MED designed to

comply with applicable federal and/or state statutory and regulatory requirements in accordance with THE MED's compliance plan, including, but not limited, adherence to the THE MED's Code of Conduct.


IN WITNESS WHEREOF, the parties have entered into this Agreement as of the day and year first state above.



University of Tennessee
Anthony A. Ferrara
Vice Chancellor, Finance and Operations

6.22.11

Date



Regional Medical Center
Reginald Coopwood, MD
Chief Executive Officer

6/17/2011

Date

Exhibit B - FY12
Supervision of Housestaff

January 12, 2011

Department	Specialty	# Residents	Faculty to Resident Ratio	# Faculty Supervising	AAMC Rate	Benefits at 30%	Annual Cost at 70%
Medicine	Allergy/Immunology	0.0	0.500	0.000	142,000.00	184,600.00	\$ -
"	Cardiology	3.0	0.500	0.250	251,000.00	326,300.00	\$ 57,102.50
"	Dermatology	2.0	0.500	1.000	223,000.00	289,900.00	\$ 202,930.00
"	Endocrinology	1.0	0.500	0.250	149,000.00	193,700.00	\$ 33,897.50
"	Gastroenterology	2.0	0.500	0.750	232,000.00	301,600.00	\$ 158,340.00
"	Gen Internal Medicine	26.0	0.333	8.666	165,000.00	214,500.00	\$ 1,301,199.90
"	Hematology/Oncology	1.0	0.500	0.250	206,000.00	267,800.00	\$ 46,865.00
"	Infectious Disease	1.0	0.250	0.250	153,000.00	198,900.00	\$ 34,807.50
"	Nephrology	1.0	0.500	0.500	180,000.00	234,000.00	\$ 81,900.00
"	Pulmonology	3.0	0.500	0.250	185,000.00	240,500.00	\$ 84,175.00
"	Rheumatology	1.0	0.500	0.250	155,000.00	201,500.00	\$ 35,262.50
Neurology	Neurology	3.0	0.250	0.750	173,000.00	224,900.00	\$ 118,072.50
Neurosurgery	Neurosurgery	3.0	0.250	1.250	445,000.00	578,500.00	\$ 506,187.50
OB/GYN	OB/GYN	31.0	0.250	7.250	241,000.00	313,300.00	\$ 1,589,997.50
Ophthalmology	Ophthalmology	2.5	0.250	0.630	235,000.00	305,500.00	\$ 134,725.50
Orthopaedics	Orthopaedics	14.0	0.250	3.500	372,000.00	483,600.00	\$ 1,184,820.00
Otolaryngology	Otolaryngology	2.0	0.250	0.500	283,000.00	367,900.00	\$ 128,765.00
Dentistry	Oral Surgery*	3.0	0.250	0.000	-	-	\$ 239,585.00
Pathology	Pathology	0.0	0.250	0.000	185,000.00	240,500.00	\$ -
Pediatrics	Pediatrics	6.0	0.250	1.250	176,000.00	228,800.00	\$ 200,200.00
Pediatrics	Neonatology	3.0	0.250	1.250	-	-	\$ -
Psychiatry	Psychiatry	3.0	0.250	0.750	143,000.00	185,900.00	\$ 97,597.50
Radiology	Radiology	4.0	0.250	1.000	327,000.00	425,100.00	\$ 297,570.00
Surgery	Surgery	20.0	0.250	3.750	303,000.00	393,900.00	\$ 1,033,987.50
Surgery	Plastics Surgery	3.0	0.250	0.250	353,000.00	458,900.00	\$ 80,307.50
Surgery	Critical Care Surgery	2.0	0.250	0.500	313,000.00	406,900.00	\$ 142,415.00
Urology	Urology	2.0	0.250	0.500	303,000.00	393,900.00	\$ 137,865.00
		142.5		35.796			\$ 7,928,575.40

Rates reflect 2008 AAMC Associate Professor 50%ile, Southern Region. All Region data used when regional data not present.

* Assumes rate from previous schedules

MED
UT

RESIDENT SUPERVISION

PROGRAM LETTERS OF AGREEMENT

In order to ensure residents receive appropriate educational experience under adequate supervision, a Program Letter of Agreement (PLA) will be updated and signed annually by the program director and site director for each participating site providing a required program assignment. The PLA will include the following information:

- identify faculty name/or general faculty group who teaches/supervises residents;
- specify their responsibilities for teaching, supervision, and formal evaluation of residents;
- specify the duration and content of the educational experience; and
- state that residents must abide by the policies of the site, the program, and the GMEC.

A copy of the PLA will be sent to and maintained in the GME office.

Individual programs must have specialty-specific supervision policies. Listings of procedural competencies by resident name and by program can be accessed on the GME Resident Supervision web page.

INSTITUTIONAL POLICY ON RESIDENT SUPERVISION

The following resident supervision policy has been approved by the Dean of the College of Medicine: <http://www.uthsc.edu/GME/supervision.php>. Development criteria were to promote patient safety, provide educational excellence, but maintain autonomy based on demonstrated education competence. The policy is effective in all training sites without regard to patient insurance status or time of day. Residents and faculty members in training programs under the auspices of ACGME will abide by the supervision and documentation schema as noted below.

University of Tennessee Graduate Medical Education Resident Supervision Policy

<u>Resident Activity</u>	<u>Resident Activity Description of Supervision</u>	<u>Documentation of Supervision Minimum Level *</u>
A. INPATIENT CARE	New Admission Residents will notify departmental attending physician upon patient admission. The urgency of notification is based upon severity and acuity of patient. The departmental attending physician must see and evaluate the patient within one calendar day of admission.	Level # 2, Co-signature not sufficient

	Continuing Care	Departmental attending physician is personally involved in ongoing care.	Level #4
	Intensive Care	Because of the unstable nature of patients in ICUs, involvement of departmental attending physician is expected on admission and at least on a daily basis.	Level #4
	Hospital Discharge/ Transfer	The departmental attending physician must be involved in decision to discharge or transfer patient.	Level # 3 Discharge Summary Signature or Transfer Note Co-signature

B. OUTPATIENT CARE	New Patient Visit	The departmental attending physician must be present in the clinic. Every new patient must be seen by and/or discussed with the departmental attending physician.	Level # 2, Co-signature not sufficient
	Return Patient Visit	The departmental attending physician must be present in the clinic.	Level #4
	Clinic Discharge	The departmental attending physician will assure clinic discharge is appropriate.	Level #4

C. OPERATING / DELIVERY ROOM	The departmental attending physician must be notified prior to the scheduling of the procedure.	The departmental attending physician must physically be present, within the facility where the procedure occurs, for the major components of the procedure and degree of involvement documented.	Level A: Attending performing the procedure, assisted by resident
			Level B: Resident performing the procedure and the departmental attending physician is scrubbed
			Level C: Resident performing the procedure with the departmental attending physician not scrubbed, but present in Operating Room

		<p>Level D: Resident performing the procedure with the departmental attending physician not scrubbed, but present in suite or facility</p> <p>Level E: Emergency Care – immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted and in route</p>
D. CONSULTATIONS (Inpatient, Outpatient and Emergency Department)	Departmental attending physician must supervise all consults.	Level #4 consistent with patient's condition and principles of graduated responsibility.
E. RADIOLOGY/PATHOLOGY		All reports verified by departmental attending physician prior to release
F. EMERGENCY DEPARTMENT	Assigned Emergency Department Attending physician must be present in the emergency department and is the attending of record. Assigned Departmental attending physician must be involved in disposition of all patients. Patients to be admitted are then assigned to clinical Department Attending (see A.).	Level #4 consistent with patient's condition and principles of graduated responsibility.
G. ROUTINE BEDSIDE & CLINIC PROCEDURES		<p>Level #4 consistent with patient's condition and principles of graduated responsibility as outlined on GME supervision web site</p> <p>http://www.utthsc.edu/GME/supervision.php</p>

H. NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES	(e.g., Cardiac Cath, endoscopy, interventional radiology, etc)	The departmental attending physician must physically be present within the facility where the procedure occurs, for the major components of the procedure and degree of involvement documented.	<p>Level A: Attending performing the procedure, assisted by resident</p> <p>Level B: Resident performing the procedure and the departmental attending physician is assisting</p> <p>Level C: Resident performing the procedure with the departmental attending physician not assisting, but present in suite.</p> <p>Level D: Resident performing the procedure with the departmental attending physician not assisting, but present in suite or facility.</p> <p>Level E: Emergency Care – Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted and in route.</p>
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*Level of Supervision Documentation

1. Departmental attending physician Note
2. Departmental attending physician Addendum to the resident's note (not a co-signature)
3. Departmental attending physician Co-signature Implies that the departmental attending physician has reviewed the resident's note, and absent an addendum to the contrary, concurs with the content of the resident's note.
4. Resident Documentation of departmental attending physician supervision. (e.g., "I have seen and/or discussed the patient with my departmental attending physician, Dr. "X," who agrees with my assessment and plan.")

Board for Licensing Health Care Facilities



State of Tennessee

DEPARTMENT OF HEALTH

0000000186

No. of Beds 0024

This is to certify, that a license is hereby granted by the State Department of Health to

REGIONAL MED EXTENDED CARE HOSPITAL, LLC to conduct and maintain a

Hospital

REGIONAL ONE HEALTH EXTENDED CARE HOSPITAL

Located at

890 MADISON AVENUE, 4TH FLOOR, MEMPHIS

County of

SHELBY, Tennessee.

This license shall expire

DECEMBER 02

, 2017

, and is subject

to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST day of NOVEMBER, 2016.

In the Distinct Category (ies) of:

CHRONIC DISEASE HOSPITAL
PEDIATRIC BASIC HOSPITAL



By

James J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

John J. Dyer, MD

COMMISSIONER

AUG 14 17 PM 2:32

Attachment B. Orderly Development. D.1.



State of Tennessee

Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243

www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

September 1, 2017

Mr. Graham Baker, Esq.
Anderson and Baker
2120 Richard Jones Road
Nashville, TN 37215

RE: Certificate of Need Application – Regional One Extended Care Hospital - CN1708-025

The addition of 6 Long Term Care Hospital (LTCH) beds to the existing 24 bed LTCH at Regional One Extended Care Hospital. The LTCH is located at 890 Madison Avenue, 4th Floor, Memphis (Shelby County), TN 38103. The service area consists of Shelby County. The applicant is owned by Shelby County Health Care Corporation. The estimated project cost is \$2,215,000.00.

Dear Mr. Baker:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on September 1, 2017. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on December 13, 2017.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (2) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (3) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,



Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA



State of Tennessee

Health Services and Development Agency

Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243


www.tn.gov/hsda

Phone: 615-741-2364

Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: 
Melanie M. Hill
Executive Director

DATE: September 1, 2017

RE: Certificate of Need Application
Regional One Extended Care Hospital - CN1708-025

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on September 1, 2017 and end on November 1, 2017.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Graham Baker



State of Tennessee

Health Services and Development Agency

Andrew Jackson Building, 9th Floor

502 Deaderick Street

Nashville, TN 37243

www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

AUG 17 10:39

LETTER OF INTENT

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general circulation in Shelby County, Tennessee, on or before August 10, 2017, for one day.

=====

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, a licensed twenty-four (24) bed hospital providing Long Term Acute Care Hospital ("LTACH") services, owned by Shelby County Health Care Corporation, with the Applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, and to be managed by Murer Consultants, Inc., 19065 Hickory Creek Drive, Suite 115, Mokena, IL 60448, intends to file a Certificate of Need application for the addition of six (6) hospital beds limited to LTACH services. The requested six (6) additional beds will be housed on the 2nd floor of the existing building, and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately \$2,215,000.00, including a \$15,000.00 filing fee.

The anticipated date of filing the application is: August 15, 2017.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.


(Signature)

08/08/2017
(Date)

graham@grahambaker.net
(E-mail Address)

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.



State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

20170901 15:00

PUBLICATION OF INTENT

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, a licensed twenty-four (24) bed hospital providing Long Term Acute Care Hospital ("LTACH") services, owned by Shelby County Health Care Corporation, with the Applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, and to be managed by Murer Consultants, Inc., 19065 Hickory Creek Drive, Suite 115, Mokena, IL 60448, intends to file a Certificate of Need application for the addition of six (6) hospital beds limited to LTACH services. The requested six (6) additional beds will be housed on the 2nd floor of the existing building, and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately \$2,215,000.00, including a \$15,000.00 filing fee.

The anticipated date of filing the application is: August 15, 2017.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

**Health Services and Development Agency
Andrew Jackson Building, 9th Floor
500 Deaderick Street
Nashville, Tennessee 37243**

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1

Regional One Extended
Care Hospital

CN1708-025

ANDERSON & BAKER
An Association of Attorneys
2021 RICHARD JONES ROAD, SUITE 120
NASHVILLE, TENNESSEE 37215-2874

SUPPLEMENTAL #1

August 28, 2017
11:27 am

ROBERT A. ANDERSON
Direct: 615-383-3332
Facsimile: 615-383-3480

E. GRAHAM BAKER, JR.
Direct: 615-370-3380
Facsimile: 615-221-0080

August 28, 2017

Phillip Earhart, Health Services Examiner
State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Hand-Delivered

Re: Certificate of Need Application CN1708-025
Regional One Extended Care Hospital
Supplemental Responses

Dear Mr. Earhart:

Please find attached the Applicant's responses to your first set of Supplemental Questions.
Please contact me if you have any additional questions.

Sincerely,


E. Graham Baker, Jr.

Encl: As Noted

1. Section A, Executive Summary, Overview, A.8

It is noted the applicant plans to add 6 LTACH beds on the 2th floor. Please indicate if there has been any discussion with licensure that this proposal meets licensure standards.

Response: Yes, and the project meets licensure standards.

How are the LTACH beds on the fourth floor separated from the general patient population and how will the 6 beds on the second floor be separated from the general patient population?

Response: The 4th floor is a discrete unit attached to but separated from the main hospital by corridors and locked doors, and the 6 beds on the 2nd floor will be likewise separated from other services on the 2nd floor.

Please clarify if the applicant plans to de-license the 3 unstaffed LTACH beds on the 4th floor.

Response: No.

Why is adding 6 beds on the 2nd floor more financially feasible than staffing the three unstaffed LTACH beds on the 4th floor?

Response: The revenue associated with a census of 2 of the 3 beds on the 4th floor does not exceed the cost of operating the three beds. Adding the 6 bed unit, however, would require the same staffing costs (as the 3 beds), thereby permitting service to a greater number of patients in a more fiscally responsible manner.

Other than the area of the proposed 6 additional LTACH beds, what service occupies the remaining area of the 2nd floor?

Response: Currently, the 2nd floor houses the Inpatient Pharmacy for Regional One Health, the ER dispatching unit (ambulances, helicopters, etc.), and the unstaffed 6 bed patient unit.

Please explain why the placement of 30 beds on one floor/unit is not feasible.

Response: There is no room. There are 24 private patient rooms available on the floor.

Please define the CMS LTACH 25 percent threshold rule. In your response, please indicate if the applicant is adhering to this rule.

Response: For cost reporting periods beginning on or after July, 2007, the 25% rule requires cost reduction for LTACHs that admit more than 25% of LTACH admissions from a single general acute care hospital. This rule would only impact the reimbursement to the LTACH under a lesser payment, but would not impact the classification of the LTACH. The Bipartisan Budget Act of 2013, however, delayed application of the 25% rule, and implementation of the rule was suspended

through Fiscal Year 2017 (October 1, 2016 – September 30, 2017) under the 21st Century Cures Act. As such, there is a moratorium on the LTACH having to adhere to the 25% threshold rule at this time.

For the most recent year available, please verify the number of Regional One acute patient that were transferred to the LTACH.

Response: For Fiscal Year 2017 (July 1, 2016 – June 30, 2017), Regional One Health referrals account for 88 of Regional One Extended Care Hospital's discharges.

2. Section A, Project Details, Item 5. Management/Operating Entity

Please provide a brief overview of Murer Consultants and their experience in managing LTACHs.

Response: Murer Consultants is a national legal based healthcare consulting firm. Murer Consultants managed the development of this LTACH in 2014, and continues to provide management consulting services to this LTACH.

Murer Consultants has a vast amount of experience with managing LTACHs across the country having developed and/or managed more than 50 LTACHs since 1990.

3. Section A, Project Details, Item 6B-(1) Plot Plan and 6B-(2) Floor Plan

Please submit a revised plot plan that clearly includes the size of site (in acres), location of the structure (labeled), and location of the proposed construction (labeled).

Response: A revised plot plan is attached as Supplemental A.6.B.1. The LTACH is located in the Turner Tower (outlined), but there is no proposed construction. The requested beds are already located in the building on the 2nd floor.

The floor plan is noted, however please submit a revised 2nd floor plan drawing which includes labeling of patient care rooms (noting private or semi-private).

Response: The submitted 2nd floor plan indicates 6 patient rooms, each labeled as "PATIENT ROOM." Each patient room is private. A new 2nd floor footprint, with even smaller labeling but showing the location of the 6 beds in relation to the total 2nd floor, is submitted as Supplemental 2nd Floor.

What will be the mix of private and semi-private beds after project completion? Please complete the following chart unless the beds are all private:

Private/Semi-Private Bed Mix by Floor

Floor	Existing Beds	Private/Semi-Private Beds	Beds After Project	Private/Semi-Private Beds After Project
2 nd				
4 th				
Total				

Response: The chart above is not applicable. All beds are private.

Please indicate where the nurse's station is located on the proposed 2nd floor 6 bed space.

Response: The nurses' station is noted as "NURSE" on the submitted 2nd floor footprint.

Please complete the following table that identifies the location of licensed beds in the Turner Building.

Building	Floor #	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTACH	24	21
	3	Rehab	24	24
	2	Rehab	6	0
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			78	69

4. Section A, Project Details, Item 12, Square Footage and Cost per Square Footage Chart

Please discuss in detail the reasons the applicant did not staff 3 of the 24 LTACH licensed beds on the 4th floor.

Response: Following analysis of the operating costs and anticipated revenue of the 3 beds currently unutilized, it was determined that a census of 2 of the 3 beds on the 4th floor does not exceed the cost of operating those three beds. As such, the 3 beds have remained unstaffed. Adding the six (6) bed unit, however, would require the same staffing costs as the 3 unstaffed beds on the 4th floor, thereby permitting service to a greater number of patients in a more fiscally responsible manner.

Has the applicant ever staffed all existing 24 beds? If so, for what period of time?

Response: No.

What services occupied the location of the proposed 6 LTACH beds? Where are those services now?

Response: The Turner Tower was renovated in a separate CON application a few years ago. As part of that project, 6 beds were renovated on the 2nd floor and certified as rehab beds (note our existing main rehab unit – 24 beds – is located one floor up on the 3rd floor of Turner Tower). While the 6 beds on the second floor were certified as rehab beds and used in conjunction with the main rehab unit on the 3rd floor, these 6 beds were specifically focused to provide rehab service to burn patients (note our main burn unit is located one floor down on the Ground floor of Turner Tower). Due to lower occupancy of our rehab unit in recent years, the rehab patients who were being care for in those 6 beds have been moved to the 3rd floor, and the 6 bed unit on the 2nd floor has not been utilized for more than one year. Therefore, the conversion of these 6 empty beds to LTACH use will not result in the loss of any existing service at the hospital, and will enable the Applicant to better serve our patients who require such services.

5. Section B, Need, Item A Section C, Item 1.a. (Long Term Care Hospital Beds-A. Need 1.)

Please provide a copy of the chart supplied by the Tennessee Department Health, Office of Healthcare Facility Statistics the applicant references in the application.

Response: The LTACH bed need chart is attached as Supplemental TDOH LTACH Bed Need Chart.

6. Section B, Need, Item A Section C, Item 1.a. (Long Term Care Hospital Beds-A. Need 2.)

What is the existing LTACH service area (Shelby County) licensed bed occupancy for the latest Joint Annual Report year?

Response: The latest JARs available on the website are for 2015, and the number of licensed beds and occupancy rates for each LTACH in Shelby County are as follows:

Baptist Memorial Restorative Care Hospital	30	76.3%
Methodist Extended Care Hospital	36	87.4%
Select Specialty Hospital	39	94.0%
Regional MED Extended Care Hospital	24	78.2%
Total	129	85.1%

It is important to note that Methodist Extended Care Hospital closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency. Currently, only 93 LTACH beds are licensed in Shelby County (all noted above minus Methodist's 36 beds).

7. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-. B. Need 1.)

What is the savings for a typical LTACH hospital stay over short-term general acute care alternative at Regional One?

Response: The total equivalent inpatient cost per day at Regional One Health is \$3,137. The total operating expenses per day for Regional One Health Extended Care Hospital is \$1,730. With a daily differential of \$1,407 multiplied by the length of stay as reported on the most recently filed cost report of 33.75 days, the savings to retaining the patient at the short term acute care venue would average \$47,486 per Medicare patient.

8. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-B. Economic Feasibility 3.)

It is noted the applicant has no charity care designated in the Projected Data Chart. How does the applicant plan to meet the standard that at a minimum 5% of the patient population will be charity or indigent care?

Response: During the 1980s, LTACHs were created to allow hospitals to discharge medically complex patients from their facilities in order to decrease Medicare spending. The long term acute care venue was designed, and is reimbursed by Medicare, to provide an appropriate venue for this acutely ill patient population, requiring an extended length of acute care stay, within the continuum of care. While adhering to the same DRG system as the short term acute care venue of care, each LTC-DRG is adjusted for the length of stay anticipated in this venue, and reimbursement based on expected resource allocation for the provision of care.

When LTACHs were first established in Tennessee, the State designed criteria and standards which included a provision that "... a minimum of 5% of the patient population using long term acute care beds will be charity or indigent care." While the long term acute care hospital intends to serve the needs of the community and the mission of the health system, the provision of charity care is a challenging prospect for a 24 bed hospital who is seeking to admit the patient population intended by Medicare to be served in this venue of care.

Additionally, the long term acute care hospital is owned by Shelby County Health Care Corporation, which as a disproportionate share hospital ("DSH"), serves a large percentage of charity care patients. As a DSH, Regional One Health is, in turn, reimbursed for the care provided to this patient population. The long term acute care hospital is not eligible for this disproportionate share allocation to serve the unfunded patient population.

The approval of this application will increase the number of LTACH beds at our facility which will serve to strengthen the financial viability, and the ability to serve the community and mission of the health system.

9. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-A. Orderly Development. 1.)

Please provide the actual average hours per patient per day of rehabilitation provided to the patients of the applicant facility for the most recent year available. Please also do the same with nursing hours.

Response: The actual average hours per patient day for rehabilitation for the most recent year available is 0.4 hours (23 minutes) per patient day.

The actual average hours per patient day for nursing hours for the most recent year available (including productive time for RNs only) are 9.43 hours.

Utilizing projected staffing patterns and projected patient utilization, please provide the calculations that indicate that patients will be receiving 6-8 hours per patient day of nursing and therapeutic services.

Response: Due to the acuity of the patient population seen at Regional One Health Extended Care Hospital, the projected nurse staffing hours will be 9.48 (See calculation below) hour per patient day. The projected therapy staffing will be .4 hours per patient day consistent with our actual in the most recent year. Combined nursing and therapy staffing hours per patient day will be 9.88.

Direct Nursing RN Hrs Per Day	9.48
Average Daily Census	26.21
Days Per Week	7
Total RN Nursing Hours/Week	1,739
RN Hours In a Work Week	40
Direct RN Nursing FTE's Required	43

Please note: This total does not include Nursing Assistants, Director of Nursing, Quality/Infection Control, Wound Care Nursing, Nursing Educator or Unit Clerks.

10. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-A. Orderly Development. 2.)

Please indicate the latest annual average aggregate length of stay as calculated by the Health Care Finance Administration.

Response: The average length of stay as reported on the most recently-filed cost report for our LTACH is 33.75 days.

11. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-A. Orderly Development. 3.)

Please use the information in your response to Orderly Development Criterion 1 to address this criterion.

Response: The Applicant will continue to focus on nursing and therapeutic care for our patients, as emphasized in the guidelines for LTACH care. Furthermore, our projected caseload will require no more than three (3) hours per day of rehabilitation.

12. Section B, Need, Item C

The historical utilization table on the top of page 16 noting 196 total patients is noted. However, the total does not match the 2015 JAR figure. Please clarify.

Response: The historical utilization table on the top of page 16 is based on the Applicant's 2016 JAR, as stated in the "NOTE" section of the page, just below the charts, replicated below:

"ALSO, the Historic Utilization chart above is based on the 2016 JAR, which is not available on the State's website (as of the time of submission of this project)."

The Applicant provided the most current data available, as is customarily requested by the HSDA.

13. Section B, Need, Item E

The table on page 20 is noted. However, the applicant placed a comma where there should be a decimal point in the total # of patients (111.22). Please revise and submit a replacement page.

Response: Replacement pages 20 and 33 are attached.

Your response is noted. Please complete the following tables:

LTACH Utilization Trends-2013-2015

Facility	Licensed Beds	2013 Patient Days	2014 Patient Days	2015 Patient Days	'13- '15 % change	2013 % Occupancy	2014 % Occupancy	2015 % Occupancy
Region One	24							
Methodist	36							
Select Specialty	39							
Regional MED	24							
	129							
Total								

Source: LTACH JAR, 2013-2015

Response: The chart above has been changed to reflect the actual LTACHs in Shelby County for the years requested, as noted below:

LTACH Utilization Trends-2013-2015

Facility	Licensed Beds	2013 Patient Days	2014 Patient Days	2015 Patient Days	'13- '15 % change	2013 % Occupancy	2014 % Occupancy	2015 % Occupancy
Baptist	30	9,855	8,449	8,354	-15.2	90.0	77.2	76.3
Methodist	36	11,228	11,752	11,485	+2.3	85.4	89.4	87.4
Select Specialty	39	12,811	13,724	13,388	+4.5	90.0	96.4	94.0
Regional MED	24	0	1,711	6,854	n/a	0.00	19.5	84.2
Total	129	33,894	35,636	40,081	+18.25	88.4*	75.7	85.1

Source: LTACH JARs, 2013-2015

*based on 105 beds, since Regional Med was not in existence in 2013

14. Section B, Need, Item F.

Please also complete the following chart:

Facility	Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
		Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.
Reg. One	24 existing								
	6 proposed								
Total	30								

Response: Please see below:

Facility	Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
		Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.
Reg. One	24 existing	204	7755	38	88.5%	204	7755	38	88.5%
	6 proposed	48	1810	38	82.6%	48	1810	38	82.6%
Total	30	252	9565	38	87.4%	252	9565	38	87.4%

15. Section B, Economic Feasibility, Item A.1 Project Cost Chart

The lease cost of \$1,552,500 in the Project Cost Chart is noted. However, it appears the lease cost calculates to be \$2,400,000 (\$40,000 monthly x 60 months). Please clarify.

Response: The project will be integrated into an existing lease, which expires in September, 2018. While the lease does contain provisions for term renewal, the original term of the lease for this 6 bed addition is approximately one year, the lease payments for which will amount to considerably less than the FMV approximation (\$1,552,500) given in the project.

16. Section B, Economic Feasibility, Item B (Funding)

The applicant notes on page 24 the majority of Project Costs (\$1,860,000) represents the fair market of the lease. However, the lease totals \$1,552,500. Please clarify.

Response: As stated on the Project Costs Chart, the Applicant leases both the facility and equipment. The FMV of the real property (land and building) is \$1,552,500, and the FMV of the leased equipment is \$307,500. Therefore, the FMV of the real property is correctly stated as \$1,552,500, but adding the FMV of the leased equipment to that figure totals \$1,860,000, which is the majority of Project Costs.

17. Section B, Economic Feasibility, Item C - Historical Data Chart

The Historical Data Chart is noted. Please clarify if the year 2017 is annualized. If so, what are the actual month represented in 2017?

Response: The numbers reported for 2017 are for a full year. Please note that the chart identifies the fiscal year beginning as July. Therefore, the 2017 column represents a full fiscal year (from July 01, 2016 through June 30, 2017).

The breakout of 2017 "other expenses" on page 26 is noted. However, the total of \$3,472,418 appears to be incorrect. Please correct and provide a replacement page 25 and 26.

Response: Year 2017 Professional Services Contract should have totaled \$1,322,488, not 1,332,488. Please see replacement page 26.

18. Section B, Economic Feasibility, Item F – Item 2 Net Operating Margin Ratio and Item 3 Capitalization Ratio

Please clarify the reason the Net Operating Margin Ratio declined from 22.8% (2nd Year previous to current year) to 4.9% (1st Year previous to current year).

Response: It is common for new long term acute care hospitals to have a higher cost to charge ratio upon start-up of operations. Given that Medicare reimburses hospitals for patients who greatly exceed the anticipated length of stay (referred to as outliers) based on the cost to charge ratio, and the long term acute care hospital had a significant number of outliers which were reimbursed under this methodology, there was a larger net operating margin in our initial year of operations than in more current years.

The capitalization ratio of 0.15% is noted. However, the ratio appears to calculate at 14.68%. Please clarify.

Response: You are correct, and 14.68% is the correct calculation. We misplaced the decimal point and rounded (an erroneous) 0.1468% to 0.15%.

19. Section B, Economic Feasibility, Item G

The projected payor mix table for Year One is noted. However, please clarify the reason there is no charity care designated.

Response: During the 1980s, LTACHs were created to allow hospitals to discharge medically complex patients from their facilities in order to decrease Medicare spending. The long term acute care venue was designed, and is reimbursed by Medicare, to provide an appropriate venue for this acutely ill patient population, requiring an extended length of acute care stay, within the continuum of care. While adhering to the same DRG system as the short term acute care venue of care, each LTC-DRG is adjusted for the length of stay anticipated in this venue, and reimbursement based on expected resource allocation for the provision of care.

When LTACHs were first established in Tennessee, the State designed criteria and standards which included a provision that "... a minimum of 5% of the patient population using long term acute care beds will be charity or indigent care." While the long term acute care hospital intends to serve the needs of the community and the mission of the health system, the provision of charity care is a challenging prospect for a 24 bed hospital who is seeking to admit the patient population intended by Medicare to be served in this venue of care.

Additionally, the long term acute care hospital is owned by Shelby County Health Care Corporation, which as a disproportionate share hospital ("DSH"), serves a large percentage of charity care patients. As a DSH, Regional One Health is, in turn, reimbursed for the care provided to this patient population. The long term acute care hospital is not eligible for this disproportionate share allocation to serve the unfunded patient population.

The approval of this application will increase the number of LTACH beds at our facility which will serve to strengthen the financial viability, and the ability to serve the community and mission of the health system.

20. Section B, Economic Feasibility, Item G

The projected staffing table on page 37 is noted. However, there appears to be slight calculation errors in the existing FTE and Projected FTE columns. Please verify and submit a replacement page 37 if necessary.

Response: Please see replacement page 37.

21. Section B, Economic Feasibility, Item I. (1)

The applicant notes the LTACH moratorium expires in October 2017. Please provide official documentation.

Response: The moratorium was first introduced in the Medicare, Medicaid and SCHIP Extension Act of 2007 which put into place a moratorium on the establishment of long-term care hospitals, long term care satellite facilities and on the increase of long-term care hospital beds in existing long term acute care hospitals or satellite facilities unless a noted exception was met.

The Bipartisan Budget Act of 2013 provided for an extension of the moratorium on establishment of and any increase in beds for LTACHs for the time period of January 1, 2015 – September 30, 2017.

The Protecting Access to Medicare Act of 2014, amended the time period by striking “January 1, 2015” and inserting the date of enactment of April 2014, but did not amend the end date of September 30, 2017.

Therefore, the moratorium expires on September 30, 2017.

The requested official documentation is attached (in order as referenced above) as Supplemental B.EF.I.1.a, Supplemental B.EF.I.1.b, and Supplemental B.EF.I.1.c.

22. Section B, Orderly Development, Item D (1) and D (2)

It is noted the applicant submitted a plan of correction on March 3, 2017 as a result of the licensure January 11, 2017 survey. Please provide documentation that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: Please see Supplemental B.OD.D.2.

23. Section B. Quality Measures

Please discuss the applicant's commitment to the proposal in meeting appropriate quality standards by addressing each of the following factors:

- (a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

Response: The Applicant so commits.

- (b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

Response: The Applicant so commits.

- (c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

Response: The Applicant so commits.

- (d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

Response: The Applicant so commits.

- (e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Response: The Applicant has maintained substantial compliance since licensing, in 2014.

- (f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Response: No.

- (g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Response: The Applicant so commits.

- (h) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Response: The Applicant so commits.

1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable.

Response: The Applicant is not accredited by any nationally recognized program, and accreditation is not required for the operation of an LTACH. If CMS requires accreditation in the future, we will comply.

August 28, 2017

11:27 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Regional One Extended Care Facility, CN1708-025

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.


Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28TH day of August, 20 17, witness my hand at office in the County of Davidson, State of Tennessee.

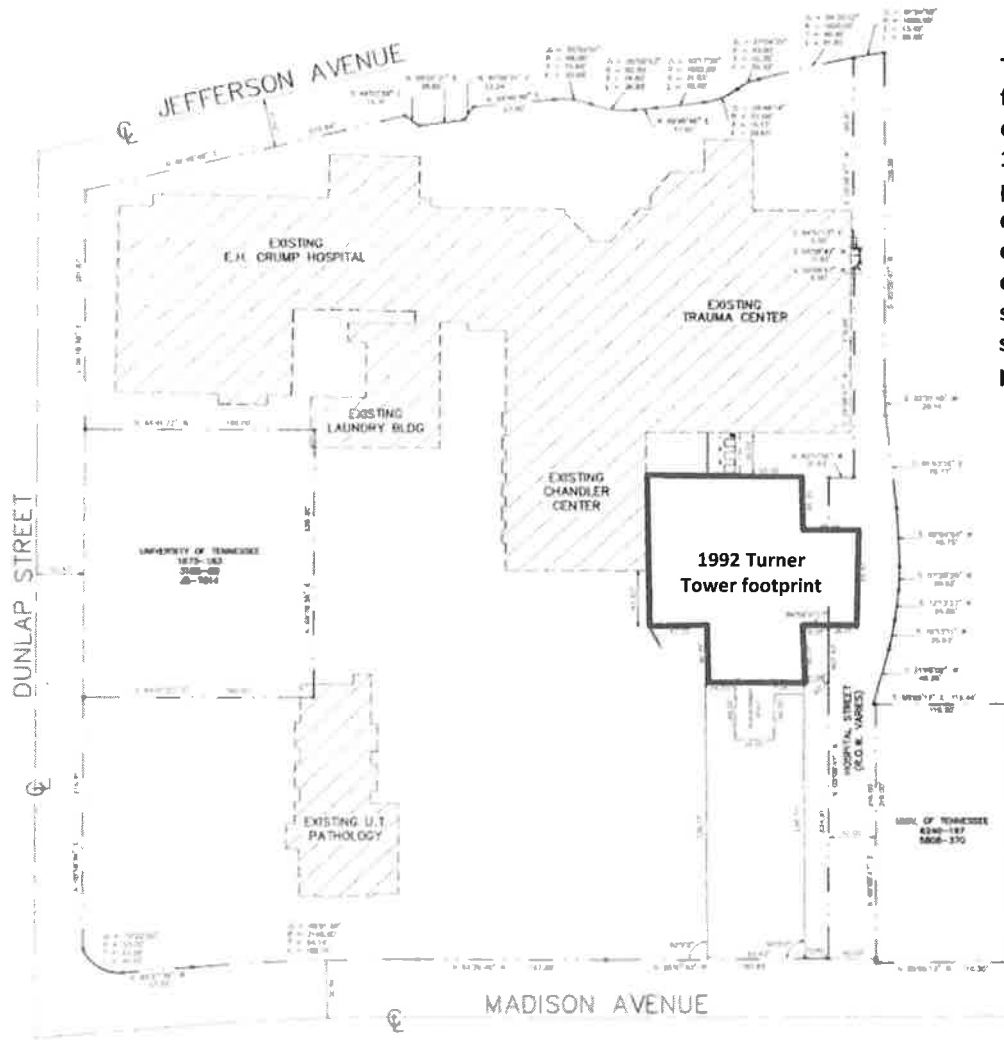

NOTARY PUBLIC

My commission expires 3/3/20.

HF-0043

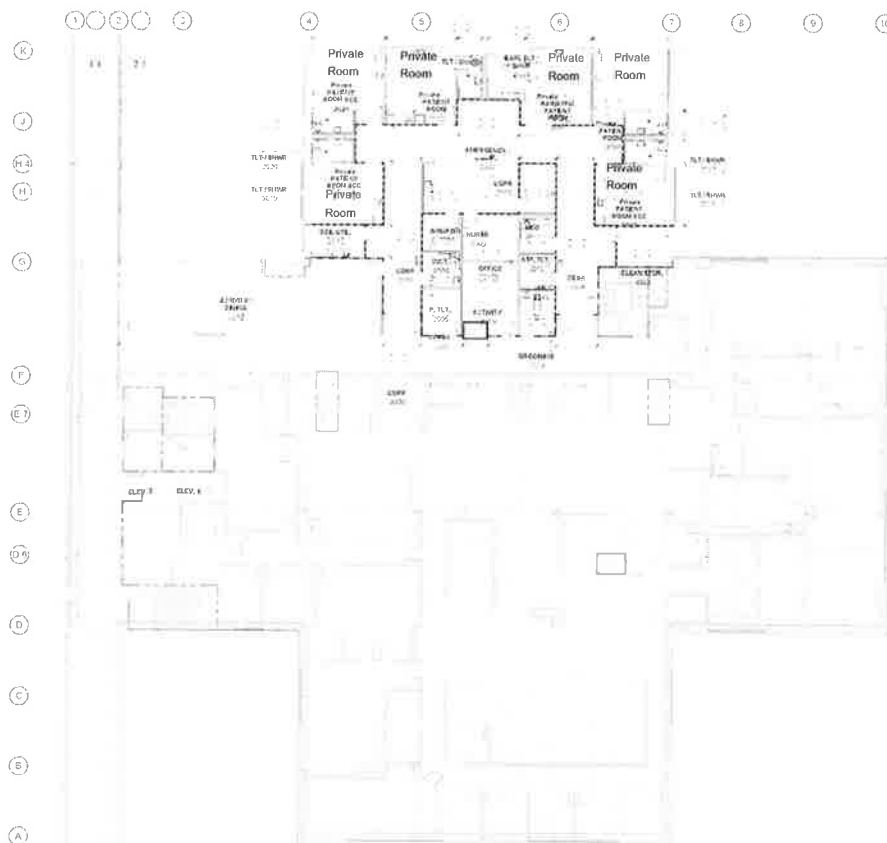
Revised 7/02





This is the original site plan from the building construction completed in 1992. The interior buildout project completed in 2014 did not include any work outside the building envelope. There was no sitework involved and no site plan was generated for permitting purposes.

18.55 Acres \pm



1 2ND FLOOR DIMENSION PLAN - REHAB - TURNER TOWER



APM
Architectural Project Management

DESIGN DEVELOPMENT
REGIONAL MEDICAL CENTER
AT MEMPHIS
TURNER TOWER RENOVATION

KEY PLAN



DESIGN DEVELOPMENT
REGIONAL MEDICAL CENTER
AT MEMPHIS
TURNER TOWER RENOVATION

DESIGN DEVELOPMENT
REGIONAL MEDICAL CENTER
AT MEMPHIS
TURNER TOWER RENOVATION

Formula for 0.5 Long Term Care Beds per 10,000 Population by County

County	2017	2019	County	2017	2019	County	2017	2019
Anderson	4	4	Hamilton	18	18	Morgan	1	1
Bedford	3	3	Hancock	0	0	Obion	2	2
Benton	1	1	Hardeman	1	1	Overton	1	1
Bledsoe	1	1	Hardin	1	1	Perry	0	0
Blount	7	7	Hawkins	3	3	Pickett	0	0
Bradley	5	5	Haywood	1	1	Polk	1	1
Campbell	2	2	Henderson	1	2	Putnam	4	4
Cannon	1	1	Henry	2	2	Rhea	2	2
Carroll	1	1	Hickman	1	1	Roane	3	3
Carter	3	3	Houston	0	0	Robertson	4	4
Cheatham	2	2	Humphreys	1	1	Rutherford	16	17
Chester	1	1	Jackson	1	1	Scott	1	1
Claiborne	2	2	Jefferson	3	3	Sequatchie	1	1
Clay	0	0	Johnson	1	1	Sevier	5	5
Cocke	2	2	Knox	24	24	Shelby	48	49
Coffee	3	3	Lake	0	0	Smith	1	1
Crockett	1	1	Lauderdale	1	1	Stewart	1	1
Cumberland	3	3	Lawrence	2	2	Sullivan	8	8
Davidson	34	35	Lewis	1	1	Sumner	9	9
Decatur	1	1	Lincoln	2	2	Tipton	3	4
DeKalb	1	1	Loudon	3	3	Trousdale	0	0
Dickson	3	3	McMinn	3	3	Unicoi	1	1
Dyer	2	2	McNairy	1	1	Union	1	1
Fayette	2	2	Macon	1	1	Van Buren	0	0
Fentress	1	1	Madison	5	5	Warren	2	2
Franklin	2	2	Marion	1	1	Washington	7	7
Gibson	3	3	Marshall	2	2	Wayne	1	1
Giles	2	2	Maury	4	5	Weakley	2	2
Grainger	1	1	Meigs	1	1	White	1	1
Greene	4	4	Monroe	2	2	Williamson	11	12
Grundy	1	1	Montgomery	10	11	Wilson	7	7
Hamblen	3	3	Moore	0	0			

Population Data: The University of Tennessee Center for Business and Economic Research Population Projection Data Files (2017 Revision, 5/17), Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.
 Note: These data will not match the University of Tennessee Data exactly due to rounding.

Source: Tennessee Department of Health, Office of Healthcare Facility Statistics.

August 28, 2017

11:27 am

- E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response: Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) and listed in that order are indicated in the chart below. These numbers are taken off the most recent JARs available (2015).

The Applicant (Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, noted as "Regional Med" in the chart below) lists data for 2017, our most recent data. It is important to note that the Applicant has been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor would result in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity.

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	\$6,987.64	\$5,283.73	\$1,703.91
Methodist	36	31.46	87.4%	\$4,023.54	\$2,661.94	\$1,361.60
Select Specialty	39	36.66	94.0%	\$10,507.78	\$7,388.76	\$3,119.02
Regional MED	24	20.21	84.2%	\$8,499.58	\$6,683.20	\$1,816.38
Total	129	111.22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day
 Adj. = Contractual Adjustments per Patient Day
 Net = Net Operating Revenue per Patient Day

Also, Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

- 3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Our existing (and projected) service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) are indicated in the chart below. These numbers are taken off the most recent JARs available (2015). It is important to note that Methodist Extended Care is now closed.

The Applicant (Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, noted as “Regional Med” in the chart below) lists data for 2017, our most recent data. It is important to note that the Applicant has been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor would result in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity.

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SUPPLEMENTAL #1**NET INCOME (LOSS)**\$3,335,216\$642,381 **August 28, 2017** \$634,500**11:27 am****G. Other Deductions**

1. Annual Principal Debt Repayment

\$\$\$

2. Annual Capital Expenditure

Total Other Deductions\$\$\$**NET BALANCE**\$3,335,216\$642,381\$634,500**DEPRECIATION**\$\$\$**FREE CASH FLOW (Net Balance + Depreciation)**\$3,335,216\$642,381\$634,500☐ **Total Facility**☐ **Project Only****HISTORICAL DATA CHART-OTHER EXPENSES****OTHER EXPENSES CATEGORIES****2015****2016****2017**

1. Professional Services Contract

\$528,032\$1,387,215\$1,322,488

2. Contract Labor

118,455141,66129,981

3. Imaging Interpretation Fees

66,27070,107103,065

4. Benefits

1,086,6231,066,8081,019,357

5. General & Administrative

934,746635,631429,570

6. Other

734,676543,123567,957**Total Other Expenses****\$3,468,802****\$3,844,545****\$3,472,418**

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H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: Please see chart below:

Position Classification	Existing FTE 2017	Projected FTE (Year 1)	Avg Wage \$ (contractual rate)	Avg Wage \$ Area/State
RN	38.0	53.3	32.71	31.75
CNA	9.9	10.1	13.23	12.95
Patient Care Extern	0.4	0.5	18.69	31.75
Dir. Respiratory Care	1.0	1.0	42.52	31.75
Liaison Nurse	2.0	2.0	34.88	31.75
Lead Respiratory Therapist	1.2	1.0	29.42	31.75
Occupational Therapist	0.9	0.8	47.67	31.75
Physical Therapist	0.9	0.9	48.18	31.75
Speech Pathologist	0.9	1.0	47.44	31.75
Patient Care Coordinator	4.0	3.5	30.35	31.75
Resp Ther/RRT	9.9	10.2	24.19	31.75
Medical Assistant	2.0	2.0	13.91	12.95
Physical Ther Asst	1.1	1.1	29.88	31.75
Resp Ther Tech/Cert	1.0	1.0	23.74	31.75
Patient Serv Clerk	5.6	5.5	14.57	12.95
a. Total Direct Care	78.8	93.9		
Nursing Clin Supv	0.6	1.0	45.67	43.95
Chief Nursing Officer	1.0	1.0	58.85	43.95
Dir HIM	1.0	1.0	37.02	43.95
Case Mgr/RN	1.0	1.1	33.97	43.95
HIM Coding Spec	0.4	0.1	22.00	12.95
Admitting Coordinator	1.0	1.0	19.85	12.95
Pre-Certification Nurse	0.9	1.9	33.65	12.95
CMS Data Coordinator	0.9	1.0	19.31	12.95
Admin Secretary	0.2	0.0	16.50	12.95
b. Total Non-Direct	7.0	8.1		
Contracted Therapy				
Contracted Med Dir/Diet.				
c. Total Contractual	0.0	0.0		
Total Staff (a + b + c)	85.8	102.0		

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MEDICARE, MEDICAID, AND SCHIP
EXTENSION ACT OF 2007

121 STAT. 2492

PUBLIC LAW 110-173—DEC. 29, 2007

Public Law 110-173
110th Congress

An Act

Dec. 29, 2007
[S. 2499]

To amend titles XVIII, XIX, and XXI of the Social Security Act to extend provisions under the Medicare, Medicaid, and SCHIP programs, and for other purposes.

Medicare,
Medicaid, and
SCHIP Extension
Act of 2007.
42 USC 1305
note.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) IN GENERAL.—This Act may be cited as the “Medicare, Medicaid, and SCHIP Extension Act of 2007”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE

- Sec. 101. Increase in physician payment update; extension of the physician quality reporting system.
- Sec. 102. Extension of Medicare incentive payment program for physician scarcity areas.
- Sec. 103. Extension of floor on work geographic adjustment under the Medicare physician fee schedule.
- Sec. 104. Extension of treatment of certain physician pathology services under Medicare.
- Sec. 105. Extension of exceptions process for Medicare therapy caps.
- Sec. 106. Extension of payment rule for brachytherapy; extension to therapeutic radiopharmaceuticals.
- Sec. 107. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.
- Sec. 108. Extension of authority of specialized Medicare Advantage plans for special needs individuals to restrict enrollment.
- Sec. 109. Extension of deadline for application of limitation on extension or renewal of Medicare reasonable cost contract plans.
- Sec. 110. Adjustment to the Medicare Advantage stabilization fund.
- Sec. 111. Medicare secondary payor.
- Sec. 112. Payment for part B drugs.
- Sec. 113. Payment rate for certain diagnostic laboratory tests.
- Sec. 114. Long-term care hospitals.
- Sec. 115. Payment for inpatient rehabilitation facility (IRF) services.
- Sec. 116. Extension of accommodation of physicians ordered to active duty in the Armed Services.
- Sec. 117. Treatment of certain hospitals.
- Sec. 118. Additional Funding for State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers.

TITLE II—MEDICAID AND SCHIP

- Sec. 201. Extending SCHIP funding through March 31, 2009.
- Sec. 202. Extension of transitional medical assistance (TMA) and abstinence education program.
- Sec. 203. Extension of qualifying individual (QI) program.
- Sec. 204. Medicaid DSH extension.
- Sec. 205. Improving data collection.
- Sec. 206. Moratorium on certain payment restrictions.

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TITLE III—MISCELLANEOUS

Sec. 301. Medicare Payment Advisory Commission status.

Sec. 302. Special Diabetes Programs for Type I Diabetes and Indians.

TITLE I—MEDICARE**SEC. 101. INCREASE IN PHYSICIAN PAYMENT UPDATE; EXTENSION OF THE PHYSICIAN QUALITY REPORTING SYSTEM.**

(a) INCREASE IN PHYSICIAN PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended—

(A) in paragraph (4)(B), by striking “and paragraphs (5) and (6)” and inserting “and the succeeding paragraphs of this subsection”; and

(B) by adding at the end the following new paragraph:

“(8) UPDATE FOR A PORTION OF 2008.—

“(A) IN GENERAL.—Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, for the period beginning on January 1, 2008, and ending on June 30, 2008, the update to the single conversion factor shall be 0.5 percent.

“(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR THE REMAINING PORTION OF 2008 AND 2009.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on July 1, 2008, and ending on December 31, 2008, and for 2009 and subsequent years as if subparagraph (A) had never applied.”.

(2) REVISION OF THE PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

(A) REVISION.—Section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w-4(l)(2)) is amended—

(i) by striking subparagraph (A) and inserting the following:

“(A) AMOUNT AVAILABLE.—

“(i) IN GENERAL.—Subject to clause (ii), there shall be available to the Fund the following amounts:

“(I) For expenditures during 2008, an amount equal to \$150,500,000.

“(II) For expenditures during 2009, an amount equal to \$24,500,000.

“(III) For expenditures during 2013, an amount equal to \$4,960,000,000.

“(ii) LIMITATIONS ON EXPENDITURES.—

“(I) 2008.—The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

“(II) 2009.—The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

“(III) 2013.—The amount available for expenditures during 2013 shall only be available

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for an adjustment to the update of the conversion factor under subsection (d) for that year.”; and
 (ii) in subparagraph (B), by striking “entire amount specified in the first sentence of subparagraph (A)” and all that follows and inserting the following: “entire amount available for expenditures, after application of subparagraph (A)(ii), during—

“(i) 2008 for payment with respect to physicians’ services furnished during 2008;

“(ii) 2009 for payment with respect to physicians’ services furnished during 2009; and

“(iii) 2013 for payment with respect to physicians’ services furnished during 2013.”.

(B) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(ii) SPECIAL RULE FOR COORDINATION WITH CONSOLIDATED APPROPRIATIONS ACT, 2008.—If the date of the enactment of the Consolidated Appropriations Act, 2008, occurs on or after the date described in clause (i), the amendments made by subparagraph (A) shall be deemed to be made on the day after the effective date of sections 225(c)(1) and 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(C) TRANSFER OF FUNDS TO PART B TRUST FUND.—

Amounts that would have been available to the Physician Assistance and Quality Initiative Fund under section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w-4(l)(2)) for payment with respect to physicians’ services furnished prior to January 1, 2013, but for the amendments made by subparagraph (A), shall be deposited into, and made available for expenditures from, the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(b) EXTENSION OF THE PHYSICIAN QUALITY REPORTING SYSTEM.—

(1) SYSTEM.—Section 1848(k)(2)(B) of the Social Security Act (42 U.S.C. 1395w-4(k)(2)(B)) is amended—

(A) in the heading, by inserting “AND 2009” after “2008”;

(B) in clause (i), by inserting “and 2009” after “2008”;

and

(C) in each of clauses (ii) and (iii)—

(i) by striking “, 2007” and inserting “of each of 2007 and 2008”; and

(ii) by inserting “or 2009, as applicable” after “2008”.

(2) REPORTING.—Section 101(c) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w-4 note) is amended—

(A) in the heading, by inserting “AND 2008” after “2007”;

(B) in paragraph (5), by adding at the end the following:

42 USC 1395w-4
note.

42 USC 1395w-4
note.

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“(F) EXTENSION.—For 2008 and 2009, paragraph (3) shall not apply, and the Secretary shall establish alternative criteria for satisfactorily reporting under paragraph (2) and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under paragraph (2)(B) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w-4(k)) and for reporting using the method specified in paragraph (4) of such section.”; and

(C) in paragraph (6), by striking subparagraph (C) and inserting the following new subparagraph:

“(C) REPORTING PERIOD.—The term ‘reporting period’ means—

“(i) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

“(ii) for 2008, all of 2008.”.

(c) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by subsections (a) and (b), in addition to any amounts otherwise provided in this title, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, \$25,000,000 for the period of fiscal years 2008 and 2009.

Criteria.

Appropriation authorization.

SEC. 102. EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS.

Section 1833(u) of the Social Security Act (42 U.S.C. 1395l(u)) is amended—

(1) in paragraph (1), by striking “before January 1, 2008” and inserting “before July 1, 2008”; and

(2) in paragraph (4)—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following new subparagraph:

“(D) SPECIAL RULE.—With respect to physicians’ services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians’ services furnished on December 31, 2007.”.

SEC. 103. EXTENSION OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)), as amended by section 102 of division B of the Tax Relief and Health Care Act of 2006, is amended by striking “before January 1, 2008” and inserting “before July 1, 2008”.

SEC. 104. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106-554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w-4 note) and section 104 of division B of the Tax Relief and Health Care Act of 2006 (42

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U.S.C. 1395w-4 note), is amended by striking “and 2007” and inserting “2007, and the first 6 months of 2008”.

SEC. 105. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking “December 31, 2007” and inserting “June 30, 2008”.

SEC. 106. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY; EXTENSION TO THERAPEUTIC RADIOPHARMACEUTICALS.

(a) **EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.**—Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 107(a) of division B of the Tax Relief and Health Care Act of 2006, is amended by striking “January 1, 2008” and inserting “July 1, 2008”.

(b) **PAYMENT FOR THERAPEUTIC RADIOPHARMACEUTICALS.**—Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by subsection (a), is amended—

(1) in the heading, by inserting “AND THERAPEUTIC RADIOPHARMACEUTICALS” before “AT CHARGES”;

(2) in the first sentence—

(A) by inserting “and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before July 1, 2008,” after “July 1, 2008,”;

(B) by inserting “or therapeutic radiopharmaceutical” after “the device”; and

(C) by inserting “or therapeutic radiopharmaceutical” after “each device”; and

(3) in the second sentence, by inserting “or therapeutic radiopharmaceuticals” after “such devices”.

42 USC 1395/
note.

SEC. 107. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l-4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note), is amended by striking “the 3-year period beginning on July 1, 2004” and inserting “the period beginning on July 1, 2004, and ending on June 30, 2008”.

SEC. 108. EXTENSION OF AUTHORITY OF SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS TO RESTRICT ENROLLMENT.

(a) **EXTENSION OF AUTHORITY TO RESTRICT ENROLLMENT.**—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w-28(f)) is amended by striking “2009” and inserting “2010”.

(b) **MORATORIUM.**—

42 USC 1395w-
21 note.

(1) **AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.**—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w-21 note) to designate other plans as specialized MA plans for special needs individuals under part C of title XVIII

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of the Social Security Act. The preceding sentence shall not apply to plans designated as specialized MA plans for special needs individuals under such authority prior to January 1, 2008.

(2) ENROLLMENT IN NEW PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not permit enrollment of any individual residing in an area in a specialized Medicare Advantage plan for special needs individuals under part C of title XVIII of the Social Security Act to take effect unless that specialized Medicare Advantage plan for special needs individuals was available for enrollment for individuals residing in that area on January 1, 2008.

SEC. 109. EXTENSION OF DEADLINE FOR APPLICATION OF LIMITATION ON EXTENSION OR RENEWAL OF MEDICARE REASONABLE COST CONTRACT PLANS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), in the matter preceding subclause (I), is amended by striking “January 1, 2008” and inserting “January 1, 2009”.

SEC. 110. ADJUSTMENT TO THE MEDICARE ADVANTAGE STABILIZATION FUND.

Section 1858(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395w-27a(e)(2)(A)(i)), as amended by section 3 of Public Law 110-48, is amended by striking “the Fund” and all that follows and inserting “the Fund during 2013, \$1,790,000,000.”

SEC. 111. MEDICARE SECONDARY PAYOR.

(a) IN GENERAL.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraphs:

“(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS.—

“(A) REQUIREMENT.—On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

“(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

“(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

“(B) ENFORCEMENT.—

“(i) IN GENERAL.—An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of

Penalties.

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Applicability.

\$1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

“(ii) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

“(C) SHARING OF INFORMATION.—Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

“(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

“(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

“(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

“(D) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

“(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS’ COMPENSATION LAWS AND PLANS.—

“(A) REQUIREMENT.—On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall—

“(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

“(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

“(B) REQUIRED INFORMATION.—The information described in this subparagraph is—

“(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

“(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

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“(C) TIMING.—Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

“(D) CLAIMANT.—For purposes of subparagraph (A), the term ‘claimant’ includes—

“(i) an individual filing a claim directly against the applicable plan; and

“(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

“(E) ENFORCEMENT.—

“(i) IN GENERAL.—An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of \$1,000 for each day of non-compliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

Penalties.

Applicability.

“(ii) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

“(F) APPLICABLE PLAN.—In this paragraph, the term ‘applicable plan’ means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

“(i) Liability insurance (including self-insurance).

“(ii) No fault insurance.

“(iii) Workers’ compensation laws or plans.

“(G) SHARING OF INFORMATION.—The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

“(H) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.”.

(b) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

42 USC 1395y note.

(c) IMPLEMENTATION.—For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines

Appropriation authorization.

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appropriate, of \$35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

SEC. 112. PAYMENT FOR PART B DRUGS.

(a) APPLICATION OF ALTERNATIVE VOLUME WEIGHTING IN COMPUTATION OF ASP.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w-3a(b)) is amended—

(1) in paragraph (1)(A), by inserting “for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug furnished on or after April 1, 2008” after “paragraph (3)”;

(2) in each of subparagraphs (A) and (B) of paragraph (4), by inserting “for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008,” after “paragraph (3)”; and

(3) by adding at the end the following new paragraph:

“(6) USE OF VOLUME-WEIGHTED AVERAGE SALES PRICES IN CALCULATION OF AVERAGE SALES PRICE.—

“(A) IN GENERAL.—For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) determined by—

“(i) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

“(I) the manufacturer’s average sales price (as defined in subsection (c)), determined by the Secretary without dividing such price by the total number of billing units for the National Drug Code for the billing and payment code; and

“(II) the total number of units specified under paragraph (2) sold; and

“(ii) dividing the sum determined under clause (i) by the sum of the products (for each National Drug Code assigned to such drug products) of—

“(I) the total number of units specified under paragraph (2) sold; and

“(II) the total number of billing units for the National Drug Code for the billing and payment code.

“(B) BILLING UNIT DEFINED.—For purposes of this subsection, the term ‘billing unit’ means the identifiable quantity associated with a billing and payment code, as established by the Secretary.”.

(b) TREATMENT OF CERTAIN DRUGS.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w-3a(b)), as amended by subsection (a), is amended—

(1) in paragraph (1), by inserting “paragraph (7) and” after “Subject to”; and

(2) by adding at the end the following new paragraph:

“(7) SPECIAL RULE.—Beginning with April 1, 2008, the payment amount for—

Effective date.

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“(A) each single source drug or biological described in section 1842(o)(1)(G) that is treated as a multiple source drug because of the application of subsection (c)(6)(C)(ii) is the lower of—

“(i) the payment amount that would be determined for such drug or biological applying such subsection; or

“(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied; and

“(B) a multiple source drug described in section 1842(o)(1)(G) (excluding a drug or biological that is treated as a multiple source drug because of the application of such subsection) is the lower of—

“(i) the payment amount that would be determined for such drug or biological taking into account the application of such subsection; or

“(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied.”.

SEC. 113. PAYMENT RATE FOR CERTAIN DIAGNOSTIC LABORATORY TESTS.

Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

“(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or after April 1, 2008, the payment rate for such test shall be the payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).”.

SEC. 114. LONG-TERM CARE HOSPITALS.

(a) **DEFINITION OF LONG-TERM CARE HOSPITAL.**—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Long-Term Care Hospital

“(ccc) The term ‘long-term care hospital’ means a hospital which—

“(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

“(2) has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or meets the requirements of clause (II) of section 1886(d)(1)(B)(iv);

“(3) satisfies the requirements of subsection (e); and

“(4) meets the following facility criteria:

“(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout

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their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

“(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient’s side within a moderate period of time, as determined by the Secretary; and

“(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient.”.

(b) STUDY AND REPORT ON LONG-TERM CARE HOSPITAL FACILITY AND PATIENT CRITERIA.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on the establishment of national long-term care hospital facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, long-term care hospitals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions, including timelines for implementation of patient criteria or other actions, as the Secretary determines appropriate.

(3) CONSIDERATIONS.—In conducting the study and preparing the report under this subsection, the Secretary shall consider—

(A) recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services; and

(B) ongoing work by the Secretary to evaluate and determine the feasibility of such recommendations.

(c) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES.—

(1) NO APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT TO FREESTANDING AND GRANDFATHERED LTCHS.—The Secretary shall not apply, for cost reporting periods beginning on or after the date of the enactment of this Act for a 3-year period—

(A) section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals; and

(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105-33).

(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

42 USC 1395ww
note.

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(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term “applicable long-term care hospital or satellite facility” means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act for a 3-year period.

(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—

The Secretary shall not apply, for the 3-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 3-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(d) MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES.—

(1) IN GENERAL.—During the 3-year period beginning on the date of the enactment of this Act, the Secretary shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act—

(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility; and

(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

42 USC 1395ww
note.

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(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act;

(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, \$2,500,000); or

(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility—

(i) is located in a State where there is only one other long-term care hospital; and

(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—

For purposes of this subsection, the term “existing” means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo), or otherwise, of the application of this subsection by the Secretary.

(e) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

“(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

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“(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.”.

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.

42 USC 1395ww
note.

(f) EXPANDED REVIEW OF MEDICAL NECESSITY.—

42 USC 1395ww
note.
Contracts.

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk-1(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

(A) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

Contracts.

(4) TERMINATION OF REQUIRED REVIEWS.—

(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the

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aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.

Appropriation
authorization.

(g) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by, this title, in addition to any amounts otherwise provided in this title, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, \$35,000,000 for the period of fiscal years 2008 and 2009.

SEC. 115. PAYMENT FOR INPATIENT REHABILITATION FACILITY (IRF) SERVICES.

(a) PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by adding at the end the following: “The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.”

42 USC 1395ww
note.

(2) DELAYED EFFECTIVE DATE.—The amendment made by paragraph (1) shall not apply to payment units occurring before April 1, 2008.

(b) INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.—

(1) IN GENERAL.—Section 5005 of the Deficit Reduction Act of 2005 (Public Law 109-171; 42 U.S.C. 1395ww note) is amended—

(A) in subsection (a), by striking “apply the applicable percent specified in subsection (b)” and inserting “require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,”; and

(B) by amending subsection (b) to read as follows:

“(b) CONTINUED USE OF COMORBIDITIES.—For cost reporting periods beginning on or after July 1, 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts toward the percent specified in subsection (a).”

42 USC 1395ww
note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(A) shall apply for cost reporting periods beginning on or after July 1, 2007.

(c) RECOMMENDATIONS FOR CLASSIFYING INPATIENT REHABILITATION HOSPITALS AND UNITS.—

(1) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with physicians (including geriatricians and physiatrists), administrators of inpatient rehabilitation, acute care hospitals, skilled nursing facilities, and other settings providing rehabilitation services, Medicare beneficiaries, trade organizations representing inpatient rehabilitation hospitals and units and skilled nursing facilities, and the Medicare Payment Advisory Commission, shall submit

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to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes the following:

(A) An analysis of Medicare beneficiaries' access to medically necessary rehabilitation services, including the potential effect of the 75 percent rule (as defined in paragraph (2)) on access to care.

(B) An analysis of alternatives or refinements to the 75 percent rule policy for determining criteria for inpatient rehabilitation hospital and unit designation under the Medicare program, including alternative criteria which would consider a patient's functional status, diagnosis, comorbidities, and other relevant factors.

(C) An analysis of the conditions for which individuals are commonly admitted to inpatient rehabilitation hospitals that are not included as a condition described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, to determine the appropriate setting of care, and any variation in patient outcomes and costs, across settings of care, for treatment of such conditions.

(2) 75 PERCENT RULE DEFINED.—For purposes of this subsection, the term “75 percent rule” means the requirement of section 412.23(b)(2) of title 42, Code of Federal Regulations, that 75 percent of the patients of a rehabilitation hospital or converted rehabilitation unit are in 1 or more of 13 listed treatment categories.

SEC. 116. EXTENSION OF ACCOMMODATION OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED SERVICES.

Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)), as amended by Public Law 110-54 (121 Stat. 551) is amended by striking “January 1, 2008” and inserting “July 1, 2008”.

SEC. 117. TREATMENT OF CERTAIN HOSPITALS.

(a) EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL YEAR 2008.—

(1) IN GENERAL.—Section 106(a) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note) is amended by striking “September 30, 2007” and inserting “September 30, 2008”. 42 USC 1395ww note.

(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through September 30, 2008, the special exception reclassifications made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

(3) USE OF PARTICULAR WAGE INDEX.—For purposes of implementation of this subsection, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on October 10, 2007 (72 Fed. Reg. 57634), and any subsequent corrections.

(b) DISREGARDING SECTION 508 HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act

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of 2003 (Public Law 108-173, 42 U.S.C. 1395ww note) is amended by adding at the end the following new subsection:

“(g) **DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.**—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d) of the Social Security Act for purposes of discharges occurring during fiscal year 2008, a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) shall not be taken into account and shall not prevent the other hospitals in such area from continuing such a group for such purpose.”

42 USC 1395ww
note.

(c) **CORRECTION OF APPLICATION OF WAGE INDEX DURING TAX RELIEF AND HEALTH CARE ACT EXTENSION.**—In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

(1) a reclassification of its wage index for purposes of such section was extended for the period beginning on April 1, 2007, and ending on September 30, 2007, pursuant to subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note); and

(2) the wage index applicable for such hospital during such period was lower than the wage index applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007,

the Secretary shall apply the higher wage index that was applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007, for the entire fiscal year 2007. If the Secretary determines that the application of the preceding sentence to a hospital will result in a hospital being owed additional reimbursement, the Secretary shall make such payments within 90 days after the settlement of the applicable cost report.

Deadline.

Grants.

SEC. 118. ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS, AREA AGENCIES ON AGING, AND AGING AND DISABILITY RESOURCE CENTERS.

(a) **STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall use amounts made available under paragraph (2) to make grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

(2) **FUNDING.**—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w-23(f)), of \$15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2008.

(b) **AREA AGENCIES ON AGING AND AGING AND DISABILITY RESOURCE CENTERS.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall use amounts made available under paragraph (2) to make grants—

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(A) to States for area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)); and

(B) to Aging and Disability Resource Centers under the Aging and Disability Resource Center grant program.

(2) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w-23(f)), of \$5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008 through 2009.

TITLE II—MEDICAID AND SCHIP

SEC. 201. EXTENDING SCHIP FUNDING THROUGH MARCH 31, 2009.

(a) THROUGH THE SECOND QUARTER OF FISCAL YEAR 2009.—

(1) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(A) in subsection (a)—

(i) by striking “and” at the end of paragraph (9);

(ii) by striking the period at the end of paragraph

(10) and inserting “; and”; and

(iii) by adding at the end the following new paragraph:

“(11) for each of fiscal years 2008 and 2009, \$5,000,000,000.”; and

(B) in subsection (c)(4)(B), by striking “for fiscal year 2007” and inserting “for each of fiscal years 2007 through 2009”.

(2) AVAILABILITY OF EXTENDED FUNDING.—Funds made available from any allotment made from funds appropriated under subsection (a)(11) or (c)(4)(B) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal year 2008 or 2009 shall not be available for child health assistance for items and services furnished after March 31, 2009, or, if earlier, the date of the enactment of an Act that provides funding for fiscal years 2008 and 2009, and for one or more subsequent fiscal years for the State Children’s Health Insurance Program under title XXI of the Social Security Act.

(3) END OF FUNDING UNDER CONTINUING RESOLUTION.—Section 136(a)(2) of Public Law 110-92 is amended by striking “after the termination date” and all that follows and inserting “after the date of the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007.”.

Ante, p. 994.

(4) CLARIFICATION OF APPLICATION OF FUNDING UNDER CONTINUING RESOLUTION.—Section 107 of Public Law 110-92 shall apply with respect to expenditures made pursuant to section 136(a)(1) of such Public Law.

(b) EXTENSION OF TREATMENT OF QUALIFYING STATES; RULES ON REDISTRIBUTION OF UNSPENT FISCAL YEAR 2005 ALLOTMENTS MADE PERMANENT.—

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(1) IN GENERAL.—Section 2105(g)(1)(A) of the Social Security Act (42 U.S.C. 1397ee(g)(1)(A)), as amended by subsection (d) of section 136 of Public Law 110-92, is amended by striking “or 2008” and inserting “2008, or 2009”.

42 USC 1397ee
note.

(2) APPLICABILITY.—The amendment made by paragraph (1) shall be in effect through March 31, 2009.

(3) CERTAIN RULES MADE PERMANENT.—Subsection (e) of section 136 of Public Law 110-92 is repealed.

Ante, p. 994.

(c) ADDITIONAL ALLOTMENTS TO ELIMINATE REMAINING FUNDING SHORTFALLS THROUGH MARCH 31, 2009.—

(1) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following new subsections:

“(j) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS FOR FISCAL YEAR 2008.—

“(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed \$1,600,000,000 for fiscal year 2008.

“(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of November 30, 2007, that the Federal share amount of the projected expenditures under such plan for such State for fiscal year 2008 will exceed the sum of—

“(A) the amount of the State’s allotments for each of fiscal years 2006 and 2007 that will not be expended by the end of fiscal year 2007;

“(B) the amount, if any, that is to be redistributed to the State during fiscal year 2008 in accordance with subsection (i); and

“(C) the amount of the State’s allotment for fiscal year 2008.

“(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2008, the Secretary shall allot—

“(A) to each shortfall State described in paragraph (2) not described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

“(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

“(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

“(5) **RETROSPECTIVE ADJUSTMENT.**—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2008, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

“(6) **ONE-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.**—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2008, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2008. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

“(k) **REDISTRIBUTION OF UNUSED FISCAL YEAR 2006 ALLOTMENTS TO STATES WITH ESTIMATED FUNDING SHORTFALLS DURING THE FIRST 2 QUARTERS OF FISCAL YEAR 2009.**—

“(1) **IN GENERAL.**—Notwithstanding subsection (f) and subject to paragraphs (3) and (4), with respect to months beginning during the first 2 quarters of fiscal year 2009, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2006 under subsection (b) that are not expended by the end of fiscal year 2008, to a fiscal year 2009 shortfall State described in paragraph (2), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for such State for the month.

“(2) **FISCAL YEAR 2009 SHORTFALL STATE DESCRIBED.**—A fiscal year 2009 shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

“(A) the amount of the State’s allotments for each of fiscal years 2007 and 2008 that was not expended by the end of fiscal year 2008; and

“(B) the amount of the State’s allotment for fiscal year 2009.

“(3) **FUNDS REDISTRIBUTED IN THE ORDER IN WHICH STATES REALIZE FUNDING SHORTFALLS.**—The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to fiscal year 2009 shortfall States described in paragraph (2) in the order in which such States realize monthly funding shortfalls under this title for fiscal year 2009. The Secretary shall only make redistributions under this subsection to the extent that there are unexpended fiscal year 2006 allotments under subsection (b) available for such redistributions.

“(4) **PRORATION RULE.**—If the amounts available for redistribution under paragraph (1) are less than the total amounts of the estimated shortfalls determined for the month under that paragraph, the amount computed under such paragraph for each fiscal year 2009 shortfall State for the month shall be reduced proportionally.

“(5) **RETROSPECTIVE ADJUSTMENT.**—The Secretary may adjust the estimates and determinations made to carry out

Deadline.

this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

“(6) AVAILABILITY; NO FURTHER REDISTRIBUTION.—Notwithstanding subsections (e) and (f), amounts redistributed to a State pursuant to this subsection for the first 2 quarters of fiscal year 2009 shall only remain available for expenditure by the State through March 31, 2009, and any amounts of such redistributions that remain unexpended as of such date, shall not be subject to redistribution under subsection (f).

“(1) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS FOR THE FIRST 2 QUARTERS OF FISCAL YEAR 2009.—

“(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed \$275,000,000 for the first 2 quarters of fiscal year 2009.

“(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

“(A) the amount of the State’s allotments for each of fiscal years 2007 and 2008 that will not be expended by the end of fiscal year 2008;

“(B) the amount, if any, that is to be redistributed to the State during fiscal year 2009 in accordance with subsection (k); and

“(C) the amount of the State’s allotment for fiscal year 2009.

“(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for the first 2 quarters of fiscal year 2009, the Secretary shall allot—

“(A) to each shortfall State described in paragraph (2) not described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

“(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

“(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

“(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out

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this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

“(6) AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2009, subject to paragraph (5), shall only remain available for expenditure by the State through March 31, 2009. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).”.

SEC. 202. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM.

Section 401 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109-432, 120 Stat. 2994), as amended by section 1 of Public Law 110-48 (121 Stat. 244) and section 2 of the TMA, Abstinence, Education, and QI Programs Extension Act of 2007 (Public Law 110-90, 121 Stat. 984), is amended—

(1) by striking “December 31, 2007” and inserting “June 30, 2008”; and

(2) by striking “first quarter” and inserting “third quarter” each place it appears.

SEC. 203. EXTENSION OF QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “December 2007” and inserting “June 2008”.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g)(2) of the Social Security Act (42 U.S.C. 1396u-3(g)(2)) is amended—

(1) in subparagraph (G), by striking “and” at the end;

(2) in subparagraph (H), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(I) for the period that begins on January 1, 2008, and ends on June 30, 2008, the total allocation amount is \$200,000,000.”.

SEC. 204. MEDICAID DSH EXTENSION.

Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r-4(f)(6)) is amended—

(1) in the heading, by inserting “AND PORTIONS OF FISCAL YEAR 2008” after “FISCAL YEAR 2007”; and

(2) in subparagraph (A)—

(A) in clause (i), by adding at the end (after and below subclause (II)) the following:

“Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be $\frac{3}{4}$ of the amount specified in the previous sentence for fiscal year 2007.”;

(B) in clause (ii)—

(i) by inserting “or for a period in fiscal year 2008 described in clause (i)” after “fiscal year 2007”; and

(ii) by inserting “or period” after “such fiscal year”; and

Tennessee.

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(C) in clause (iv)—

(i) in the heading, by inserting “AND FISCAL YEAR 2008” after “FISCAL YEAR 2007”;

(ii) in subclause (I)—

(I) by inserting “or for a period in fiscal year 2008 described in clause (i)” after “fiscal year 2007”; and

(II) by inserting “or period” after “for such fiscal year”; and

(iii) in subclause (II)—

(I) by inserting “or for a period in fiscal year 2008 described in clause (i)” after “fiscal year 2007”; and

(II) by inserting “or period” after “such fiscal year” each place it appears; and

Hawaii.

(3) in subparagraph (B)(i), by adding at the end the following: “Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$7,500,000.”.

SEC. 205. IMPROVING DATA COLLECTION.

Section 2109(b)(2) of the Social Security Act (42 U.S.C. 1397ii(b)(2)) is amended by inserting before the period at the end the following “(except that only with respect to fiscal year 2008, there are appropriated \$20,000,000 for the purpose of carrying out this subsection, to remain available until expended)”.

SEC. 206. MORATORIUM ON CERTAIN PAYMENT RESTRICTIONS.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to June 30, 2008, take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose any restrictions relating to coverage or payment under title XIX of the Social Security Act for rehabilitation services or school-based administration and school-based transportation if such restrictions are more restrictive in any aspect than those applied to such areas as of July 1, 2007.

TITLE III—MISCELLANEOUS**SEC. 301. MEDICARE PAYMENT ADVISORY COMMISSION STATUS.**

Section 1805(a) of the Social Security Act (42 U.S.C. 1395b-6(a)) is amended by inserting “as an agency of Congress” after “established”.

SEC. 302. SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c-2(b)(2)(C)) is amended by striking “2008” and inserting “2009”.

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(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c-3(c)(2)(C)) is amended by striking “2008” and inserting “2009”.

Approved December 29, 2007.

LEGISLATIVE HISTORY—S. 2499:

CONGRESSIONAL RECORD, Vol. 153 (2007):

Dec. 18, considered and passed Senate.

Dec. 19, considered and passed House.



One Hundred Thirteenth Congress
of the
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Thursday,
the third day of January, two thousand and thirteen*

Joint Resolution

Making continuing appropriations for fiscal year 2014, and for other purposes.

*Resolved by the Senate and House of Representatives of the
United States of America in Congress assembled, That*

**DIVISION A—BIPARTISAN BUDGET
AGREEMENT**

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the “Bipartisan Budget Act of 2013”.

(b) TABLE OF CONTENTS.—The table of contents of this division is as follows:

DIVISION A—BUDGET ENFORCEMENT AND DEFICIT REDUCTION

Sec. 1. Short title and table of contents.

TITLE I—BUDGET ENFORCEMENT

Subtitle A—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985

Sec. 101. Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985.

Subtitle B—Establishing a Congressional Budget

Sec. 111. Fiscal year 2014 budget resolution.

Sec. 112. Limitation on advance appropriations in the Senate.

Sec. 113. Rule of construction in the House of Representatives.

Sec. 114. Additional Senate budget enforcement.

Sec. 115. Authority for fiscal year 2015 budget resolution in the House of Representatives.

Sec. 116. Authority for fiscal year 2015 budget resolution in the Senate.

Sec. 117. Exclusion of savings from PAYGO scorecards.

Sec. 118. Exercise of rulemaking powers.

Subtitle C—Technical Corrections

Sec. 121. Technical corrections to the Balanced Budget and Emergency Deficit Control Act of 1985.

Sec. 122. Technical corrections to the Congressional Budget Act of 1974.

TITLE II—PREVENTION OF WASTE, FRAUD, AND ABUSE

Sec. 201. Improving the collection of unemployment insurance overpayments.

Sec. 202. Strengthening Medicaid Third-Party Liability.

Sec. 203. Restriction on access to the death master file.

Sec. 204. Identification of inmates requesting or receiving improper payments.

TITLE III—NATURAL RESOURCES

Sec. 301. Ultra-deepwater and unconventional natural gas and other petroleum resources.

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- Sec. 302. Amendment to the Mineral Leasing Act.
- Sec. 303. Approval of agreement with Mexico.
- Sec. 304. Amendment to the Outer Continental Shelf Lands Act.
- Sec. 305. Federal oil and gas royalty prepayment cap.
- Sec. 306. Strategic Petroleum Reserve.

TITLE IV—FEDERAL CIVILIAN AND MILITARY RETIREMENT

- Sec. 401. Increase in contributions to Federal Employees Retirement System for new employees.
- Sec. 402. Foreign Service Pension System.
- Sec. 403. Annual adjustment of retired pay and retainer pay amounts for retired members of the Armed Forces under age 62.

TITLE V—HIGHER EDUCATION

- Sec. 501. Default reduction program.
- Sec. 502. Elimination of nonprofit servicing contracts.

TITLE VI—TRANSPORTATION

- Sec. 601. Aviation security service fees.
- Sec. 602. Transportation cost reimbursement.
- Sec. 603. Sterile areas at airports.

TITLE VII—MISCELLANEOUS PROVISIONS

- Sec. 701. Extension of customs user fees.
- Sec. 702. Limitation on allowable government contractor compensation costs.
- Sec. 703. Pension Benefit Guaranty Corporation premium rate increases.
- Sec. 704. Cancellation of Unobligated Balances.
- Sec. 705. Conservation planning technical assistance user fees.
- Sec. 706. Self plus one coverage.

(c) REFERENCES.—Except as expressly provided otherwise, any reference to “this Act” contained in any division of this Act shall be treated as referring only to the provisions of that division.

TITLE I—BUDGET ENFORCEMENT**Subtitle A—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985****SEC. 101. AMENDMENTS TO THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985.**

(a) REVISED DISCRETIONARY SPENDING LIMITS.—Section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking paragraphs (1) through (10) and inserting the following new paragraphs:

“(1) for fiscal year 2014—

“(A) for the revised security category, \$520,464,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$491,773,000,000 in new budget authority;

“(2) for fiscal year 2015—

“(A) for the revised security category, \$521,272,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$492,356,000,000 in new budget authority;

“(3) for fiscal year 2016—

“(A) for the revised security category, \$577,000,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$530,000,000,000 in new budget authority;

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“(4) for fiscal year 2017—

“(A) for the revised security category, \$590,000,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$541,000,000,000 in new budget authority;

“(5) for fiscal year 2018—

“(A) for the revised security category, \$603,000,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$553,000,000,000 in new budget authority;

“(6) for fiscal year 2019—

“(A) for the revised security category, \$616,000,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$566,000,000,000 in new budget authority;

“(7) for fiscal year 2020—

“(A) for the revised security category, \$630,000,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$578,000,000,000 in new budget authority; and

“(8) for fiscal year 2021—

“(A) for the revised security category, \$644,000,000,000 in new budget authority; and

“(B) for the revised nonsecurity category, \$590,000,000,000 in new budget authority;”.

(b) DIRECT SPENDING ADJUSTMENTS FOR FISCAL YEARS 2014 AND 2015.—(1) Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985, as redesignated by subsection (d), is amended by adding at the end the following new paragraph:

“(10) IMPLEMENTING DIRECT SPENDING REDUCTIONS FOR FISCAL YEARS 2014 AND 2015.—(A) OMB shall make the calculations necessary to implement the direct spending reductions calculated pursuant to paragraphs (3) and (4) without regard to the amendment made to section 251(c) revising the discretionary spending limits for fiscal years 2014 and 2015 by the Bipartisan Budget Act of 2013.

“(B) Paragraph (5)(B) shall not be implemented for fiscal years 2014 and 2015.”.

(2) Paragraph (5)(B) of section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985, as redesignated by subsection (d)(2)(C) of this section, is amended by striking “On” and inserting “Except as provided by paragraph (10), on”.

(c) EXTENSION OF DIRECT SPENDING REDUCTIONS FOR FISCAL YEARS 2022 AND 2023.—Paragraph (6), as redesignated by subsection (d)(2)(C) of this section, of section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by inserting “(A)” before “On the date” and by adding at the end the following new subparagraph:

“(B) On the dates OMB issues its sequestration preview reports for fiscal year 2022 and for fiscal year 2023, pursuant to section 254(c), the President shall order a sequestration, effective upon issuance such that—

“(i) the percentage reduction for nonexempt direct spending for the defense function is the same percent as the percentage reduction for nonexempt direct spending for the defense function for fiscal year 2021 calculated under paragraph (3)(B); and

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“(ii) the percentage reduction for nonexempt direct spending for nondefense functions is the same percent as the percentage reduction for nonexempt direct spending for nondefense functions for fiscal year 2021 calculated under paragraph (4)(B).”.

(d) CONFORMING AMENDMENTS.—Part C of title II of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900 et seq.) is amended—

(1) in section 250(c)(4) (2 U.S.C. 900(c)(4)), by adding at the end the following:

“(D) The term ‘revised security category’ means discretionary appropriations in budget function 050.

“(E) The term ‘revised nonsecurity category’ means discretionary appropriations other than in budget function 050.

“(F) The term ‘category’ means the subsets of discretionary appropriations in section 251(c). Discretionary appropriations in each of the categories shall be those designated in the joint explanatory statement accompanying the conference report on the Balanced Budget Act of 1997. New accounts or activities shall be categorized only after consultation with the Committees on Appropriations and the Budget of the House of Representatives and the Senate and that consultation shall, to the extent practicable, include written communication to such committees that affords such committees the opportunity to comment before official action is taken with respect to new accounts or activities.”; and

(2) in section 251A (2 U.S.C. 901a)—

(A) by striking, in the matter preceding paragraph (1), “Unless” through “as follows:” and inserting the following: “Discretionary appropriations and direct spending accounts shall be reduced in accordance with this section as follows:”;

(B) by striking paragraphs (1) and (2);

(C) by redesignating paragraphs (3) through (11) as paragraphs (1) through (9), respectively;

(D) in paragraph (2), as redesignated, by striking “paragraph (3)” and inserting “paragraph (1)”;

(E) in paragraph (3), as redesignated, by striking “paragraph (4)” each place it appears and inserting “paragraph (2)”;

(F) in paragraph (4), as redesignated, by striking “paragraph (4)” each place it appears and inserting “paragraph (2)”;

(G) in paragraph (5), as redesignated—

(i) by striking “paragraph (5)” each place it appears and inserting “paragraph (3)”;

(ii) by striking “paragraph (6)” each place it appears and inserting “paragraph (4)”;

(H) in paragraph (6), as redesignated—

(i) by striking “paragraph (4)” and inserting “paragraph (2)”;

(ii) by striking “paragraphs (5) and (6)” and inserting “paragraphs (3) and (4)”;

(I) in paragraph (7), as redesignated—

(i) by striking “paragraph (8)” and inserting “paragraph (6)”;

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(ii) by striking “paragraph (6)” each place it appears and inserting “paragraph (4)”; and
(J) in paragraph (9), as redesignated, by striking “paragraph (4)” and inserting “paragraph (2)”.

Subtitle B—Establishing a Congressional Budget

SEC. 111. FISCAL YEAR 2014 BUDGET RESOLUTION.

(a) FISCAL YEAR 2014.—For the purpose of enforcing the Congressional Budget Act of 1974 for fiscal year 2014, and enforcing, in the Senate, budgetary points of order in prior concurrent resolutions on the budget, the allocations, aggregates, and levels provided for in subsection (b) shall apply in the same manner as for a concurrent resolution on the budget for fiscal year 2014 with appropriate budgetary levels for fiscal year 2014 and for fiscal years 2015 through 2023.

(b) COMMITTEE ALLOCATIONS, AGGREGATES, AND LEVELS.—The Chairmen of the Committee on the Budget of the House of Representatives and the Senate shall each submit a statement for publication in the Congressional Record as soon as practicable after the date of enactment of this Act that includes—

(1) for the Committee on Appropriations of that House, committee allocations for fiscal year 2014 consistent with the discretionary spending limits set forth in this Act for the purpose of enforcing section 302 of the Congressional Budget Act of 1974;

(2) for all committees of that House other than the Committee on Appropriations, committee allocations for—

(A) fiscal year 2014;

(B) fiscal years 2014 through 2018 in the Senate only;

and

(C) fiscal years 2014 through 2023; consistent with the May 2013 baseline of the Congressional Budget Office adjusted to account for the budgetary effects of this Act and legislation enacted prior to this Act but not included in the May 2013 baseline of the Congressional Budget Office, for the purpose of enforcing section 302 of the Congressional Budget Act of 1974;

(3) aggregate spending levels for fiscal year 2014 in accordance with the allocations established under paragraphs (1) and (2), for the purpose of enforcing section 311 of the Congressional Budget Act of 1974;

(4) aggregate revenue levels for—

(A) fiscal year 2014;

(B) fiscal years 2014 through 2018 in the Senate only;

and

(C) fiscal years 2014 through 2023; consistent with the May 2013 baseline of the Congressional Budget Office adjusted to account for the budgetary effects of this Act and legislation enacted prior to this Act but not included in the May 2013 baseline of the Congressional Budget Office, for the purpose of enforcing section 311 of the Congressional Budget Act of 1974; and

(5) in the Senate only, levels of Social Security revenues and outlays for fiscal year 2014 and for the periods of fiscal

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years 2014 through 2018 and 2014 through 2023 consistent with the May 2013 baseline of the Congressional Budget Office adjusted to account for the budgetary effects of this Act and legislation enacted prior to this Act but not included in the May 2013 baseline of the Congressional Budget Office, for the purpose of enforcing sections 302 and 311 of the Congressional Budget Act of 1974.

(c) FURTHER ADJUSTMENTS.—After the date of enactment of this Act, the Chairman of the Committee on the Budget of the House of Representatives may reduce the aggregates, allocations, and other budgetary levels included in the statement of the Chairman of the Committee on the Budget of the House of Representatives referred to in subsection (b) to reflect the budgetary effects of any legislation enacted during the 113th Congress that reduces the deficit.

SEC. 112. LIMITATION ON ADVANCE APPROPRIATIONS IN THE SENATE.

(a) POINT OF ORDER AGAINST ADVANCE APPROPRIATIONS IN THE SENATE.—

(1) IN GENERAL.—

(A) POINT OF ORDER.—Except as provided in paragraph (2), it shall not be in order in the Senate to consider any bill, joint resolution, motion, amendment, amendment between the Houses, or conference report that would provide an advance appropriation.

(B) DEFINITION.—In this subsection, the term “advance appropriation” means any new budget authority provided in a bill or joint resolution making appropriations for fiscal year 2014 that first becomes available for any fiscal year after 2014 or any new budget authority provided in a bill or joint resolution making appropriations for fiscal year 2015 that first becomes available for any fiscal year after 2015.

(2) EXCEPTIONS.—Advance appropriations may be provided—

(A) for fiscal years 2015 and 2016 for programs, projects, activities, or accounts identified in a statement submitted to the Congressional Record by the Chairman of the Committee on the Budget of the Senate under the heading “Accounts Identified for Advance Appropriations” in an aggregate amount not to exceed \$28,852,000,000 in new budget authority in each fiscal year;

(B) for the Corporation for Public Broadcasting; and

(C) for the Department of Veterans Affairs for the Medical Services, Medical Support and Compliance, and Medical Facilities accounts of the Veterans Health Administration.

(3) SUPERMAJORITY WAIVER AND APPEAL.—

(A) WAIVER.—In the Senate, paragraph (1) may be waived or suspended only by an affirmative vote of three-fifths of the Members, duly chosen and sworn.

(B) APPEAL.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under paragraph (1).

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(4) **FORM OF POINT OF ORDER.**—A point of order under paragraph (1) may be raised by a Senator as provided in section 313(e) of the Congressional Budget Act of 1974.

(5) **CONFERENCE REPORTS.**—When the Senate is considering a conference report on, or an amendment between the Houses in relation to, a bill, upon a point of order being made by any Senator pursuant to this subsection, and such point of order being sustained, such material contained in such conference report or amendment between the Houses shall be stricken, and the Senate shall proceed to consider the question of whether the Senate shall recede from its amendment and concur with a further amendment, or concur in the House amendment with a further amendment, as the case may be, which further amendment shall consist of only that portion of the conference report or House amendment, as the case may be, not so stricken. Any such motion in the Senate shall be debatable. In any case in which such point of order is sustained against a conference report (or Senate amendment derived from such conference report by operation of this paragraph), no further amendment shall be in order.

(6) **INAPPLICABILITY.**—In the Senate, section 402 of S. Con. Res. 13 (111th Congress) shall no longer apply.

(b) **EXPIRATION.**—Subsection (a) shall expire if a concurrent resolution on the budget for fiscal year 2015 is agreed to by the Senate and House of Representatives pursuant to section 301 of the Congressional Budget Act of 1974.

SEC. 113. RULE OF CONSTRUCTION IN THE HOUSE OF REPRESENTATIVES.

In the House of Representatives, for the remainder of the 113th Congress, the provisions of H. Con. Res. 25 (113th Congress), as deemed in force by H. Res. 243 (113th Congress), shall remain in force to the extent its budgetary levels are not superseded by this subtitle or by further action of the House of Representatives.

SEC. 114. ADDITIONAL SENATE BUDGET ENFORCEMENT.

(a) **SENATE PAY-AS-YOU-GO SCORECARD.**—

(1) **IN GENERAL.**—Effective on the date of enactment of this Act, for the purpose of enforcing section 201 of S. Con. Res. 21 (110th Congress), the Chairman of the Committee on the Budget of the Senate shall reduce any balances of direct spending and revenues for any fiscal year to zero.

(2) **FISCAL YEAR 2015.**—After April 15, 2014, but not later than May 15, 2014, for the purpose of enforcing section 201 of S. Con. Res. 21 (110th Congress), the Chairman of the Committee on the Budget of the Senate shall reduce any balances of direct spending and revenues for any fiscal year to zero.

(3) **PUBLICATION.**—Upon resetting the Senate paygo scorecard pursuant to paragraph (2), the Chairman of the Committee on the Budget of the Senate shall publish a notification of such action in the Congressional Record.

(b) **FURTHER ADJUSTMENTS.**—With respect to any allocations, aggregates, or levels set or adjustments made pursuant to this subtitle, sections 412 through 414 of S. Con. Res. 13 (111th Congress) shall remain in effect.

(c) **DEFICIT-NEUTRAL RESERVE FUND TO REPLACE SEQUESTRATION.**—The Chairman of the Committee on the Budget of the Senate

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may revise the allocations of a committee or committees, aggregates, and other appropriate levels and limits set pursuant to this subtitle for one or more bills, joint resolutions, amendments, motions, or conference reports that amend section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a) to repeal or revise the enforcement procedures established under that section, by the amounts provided in such legislation for those purposes, provided that such legislation would not increase the deficit over the period of the total of fiscal years 2014 through 2023. For purposes of determining deficit-neutrality under this subsection, the Chairman may include the estimated effects of any amendment or amendments to the discretionary spending limits in section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(c)).

(d) **ADDITIONAL DEFICIT-NEUTRAL RESERVE FUNDS.**—In the Senate only, sections 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 338, 339, 340, 341, 344, 348, 349, 350, 353, 354, 356, 361, 363, 364, 365, 366, 367, 368, 369, 371, 376, 378, 379, and 383 of S. Con. Res. 8 (113th Congress), as passed the Senate, shall have force and effect.

(e) **EXPIRATION.**—Subsections (a)(2), (c), and (d) shall expire if a concurrent resolution on the budget for fiscal year 2015 is agreed to by the Senate and House of Representatives pursuant to section 301 of the Congressional Budget Act of 1974.

SEC. 115. AUTHORITY FOR FISCAL YEAR 2015 BUDGET RESOLUTION IN THE HOUSE OF REPRESENTATIVES.

(a) **FISCAL YEAR 2015.**—If a concurrent resolution on the budget for fiscal year 2015 has not been adopted by April 15, 2014, for the purpose of enforcing the Congressional Budget Act of 1974, the allocations, aggregates, and levels provided for in subsection (b) shall apply in the House of Representatives after April 15, 2014, in the same manner as for a concurrent resolution on the budget for fiscal year 2015 with appropriate budgetary levels for fiscal year 2015 and for fiscal years 2016 through 2024.

(b) **COMMITTEE ALLOCATIONS, AGGREGATES, AND LEVELS.**—In the House of Representatives, the Chairman of the Committee on the Budget shall submit a statement for publication in the Congressional Record after April 15, 2014, but not later than May 15, 2014, containing—

(1) for the Committee on Appropriations, committee allocations for fiscal year 2015 at the total level as set forth in section 251(c)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 for the purpose of enforcing section 302 of the Congressional Budget Act of 1974;

(2) for all committees other than the Committee on Appropriations, committee allocations for fiscal year 2015 and for the period of fiscal years 2015 through 2024 at the levels included in the most recent baseline of the Congressional Budget Office, as adjusted for the budgetary effects of any provision of law enacted during the period beginning on the date such baseline is issued and ending on the date of submission of such statement, for the purpose of enforcing section 302 of the Congressional Budget Act of 1974; and

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(3) aggregate spending levels for fiscal year 2015 and aggregate revenue levels for fiscal year 2015 and for the period of fiscal years 2015 through 2024, at the levels included in the most recent baseline of the Congressional Budget Office, as adjusted for the budgetary effects of any provision of law enacted during the period beginning on the date such baseline is issued and ending on the date of submission of such statement, for the purpose of enforcing section 311 of the Congressional Budget Act of 1974.

(c) ADDITIONAL MATTER.—The statement referred to in subsection (b) may also include for fiscal year 2015, the matter contained in title IV (reserve funds) and in sections 601, 603(a), 605(a), and 609 of H. Con. Res. 25 (113th Congress), as adopted by the House, updated by one fiscal year, including updated amounts for section 601.

(d) FISCAL YEAR 2015 ALLOCATION TO THE COMMITTEE ON APPROPRIATIONS.—If the statement referred to in subsection (b) is not filed by May 15, 2014, then the matter referred to in subsection (b)(1) shall be submitted by the Chairman of the Committee on the Budget for publication in the Congressional Record on the next day that the House of Representatives is in session.

(e) ADJUSTMENTS.—The Chairman of the Committee on the Budget of the House of Representatives may adjust the levels included in the statement referred to in subsection (b) to reflect the budgetary effects of any legislation enacted during the 113th Congress that reduces the deficit or as otherwise necessary.

(f) APPLICATION.—Subsections (a), (b), (c), (d), and (e) shall no longer apply if a concurrent resolution on the budget for fiscal year 2015 is agreed to by the Senate and House of Representatives pursuant to section 301 of the Congressional Budget Act of 1974.

SEC. 116. AUTHORITY FOR FISCAL YEAR 2015 BUDGET RESOLUTION IN THE SENATE.

(a) FISCAL YEAR 2015.—For the purpose of enforcing the Congressional Budget Act of 1974, after April 15, 2014, and enforcing budgetary points of order in prior concurrent resolutions on the budget, the allocations, aggregates, and levels provided for in subsection (b) shall apply in the Senate in the same manner as for a concurrent resolution on the budget for fiscal year 2015 with appropriate budgetary levels for fiscal years 2014 and 2016 through 2024.

(b) COMMITTEE ALLOCATIONS, AGGREGATES, AND LEVELS.—After April 15, 2014, but not later than May 15, 2014, the Chairman of the Committee on the Budget of the Senate shall file—

(1) for the Committee on Appropriations, committee allocations for fiscal years 2014 and 2015 consistent with the discretionary spending limits set forth in this Act for the purpose of enforcing section 302 of the Congressional Budget Act of 1974;

(2) for all committees other than the Committee on Appropriations, committee allocations for fiscal years 2014, 2015, 2015 through 2019, and 2015 through 2024 consistent with the most recent baseline of the Congressional Budget Office for the purpose of enforcing section 302 of the Congressional Budget Act of 1974;

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(3) aggregate spending levels for fiscal years 2014 and 2015 in accordance with the allocations established under paragraphs (1) and (2), for the purpose of enforcing section 311 of the Congressional Budget Act of 1974;

(4) aggregate revenue levels for fiscal years 2014, 2015, 2015 through 2019, and 2015 through 2024 consistent with the most recent baseline of the Congressional Budget Office for the purpose of enforcing section 311 of the Congressional Budget Act of 1974; and

(5) levels of Social Security revenues and outlays for fiscal years 2014, 2015, 2015 through 2019, and 2015 through 2024 consistent with the most recent baseline of the Congressional Budget Office for the purpose of enforcing sections 302 and 311 of the Congressional Budget Act of 1974.

(c) **ADDITIONAL MATTER.**—The filing referred to in subsection (b) may also include, for fiscal year 2015, the reserve funds included in section 114(c) and (d) of this Act, updated by one fiscal year.

(d) **SUPERSEDING PREVIOUS STATEMENT.**—In the Senate, the filing referred to in subsection (b) shall supersede the statement referred to in section 111(b) of this Act.

(e) **EXPIRATION.**—This section shall expire if a concurrent resolution on the budget for fiscal year 2015 is agreed to by the Senate and House of Representatives pursuant to section 301 of the Congressional Budget Act of 1974.

SEC. 117. EXCLUSION OF SAVINGS FROM PAYGO SCORECARDS.

(a) **STATUTORY PAY-AS-YOU-GO SCORECARDS.**—Notwithstanding section 1(c) of this division, the budgetary effects of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010.

(b) **SENATE PAYGO SCORECARDS.**—Notwithstanding section 1(c) of this division, the budgetary effects of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 201 of S. Con. Res. 21 (110th Congress).

SEC. 118. EXERCISE OF RULEMAKING POWERS.

The provisions of this subtitle are enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they shall be considered as part of the rules of each House, respectively, or of that House to which they specifically apply, and such rules shall supersede other rules only to the extent that they are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change such rules (so far as relating to such House) at any time, in the same manner, and to the same extent as in the case of any other rule of such House.

Subtitle C—Technical Corrections

SEC. 121. TECHNICAL CORRECTIONS TO THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985.

The Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) In section 252(b)(2)(B), strike “applicable to budget year” and insert “applicable to the budget year”.

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(2) In section 252(c)(1)(C)(i), strike “paragraph (1)” and insert “subsection (b)”.

(3) In section 254(c)(3)(A), strike “subsection 252(b)” and insert “section 252(b)”.

(4) In section 254(f)(4), strike “subsection 252(b)” and insert “section 252(b)”.

(5) In section 255(a), strike “section 231b(a), 231b(f)(2), 231c(a), and 231c(f) of title 45 United States Code” and insert “sections 3 and 4 of the Railroad Retirement Act of 1937 (45 U.S.C. 231 et seq.)”.

(6) In section 255(h), in the item relating to Federal Pell Grants, strike “section 401 Title IV” and insert “section 401 of title IV”.

(7) In the first subsection (j) of section 255 (relating to Split Treatment Programs), move the margins for the list items two ems to the right.

(8) Redesignate the second subsection (j) of section 255 (relating to Identification of Programs) as subsection (k).

(9) In section 257(b)(2)(A)(i), strike “differenes” and insert “differences”.

(10) In section 258(a)(1), strike “section 254(j)” and insert “section 254(i)”.

SEC. 122. TECHNICAL CORRECTIONS TO THE CONGRESSIONAL BUDGET ACT OF 1974.

The Congressional Budget Act of 1974 is amended as follows:

(1) In sections 301(a)(6) and 301(a)(7), strike “For purposes” and insert “for purposes”.

(2) In section 301(a), in the matter following paragraph (7), strike “old age” and insert “old-age”.

(3) In section 302(g)(2)(A), strike “committee on the Budget” and insert “Committee on the Budget”.

(4) In section 305(a)(1), strike “clause 2(l)(6) of rule XI” and insert “clause 4 of rule XIII”.

(5) In section 305(a)(5), strike “provisions of rule XXIII” and insert “provisions of rule XVIII”.

(6) In section 305(b)(1), strike “section 304(a)” and insert “section 304”.

(7) In section 306 strike “No” and insert “(a) IN THE SENATE.—In the Senate, no”, strike “of either House” and “in that House”, strike “of that House”, and add at the end the following new subsection:

“(b) IN THE HOUSE OF REPRESENTATIVES.—In the House of Representatives, no bill or joint resolution, or amendment thereto, or conference report thereon, dealing with any matter which is within the jurisdiction of the Committee on the Budget shall be considered unless it is a bill or joint resolution which has been reported by the Committee on the Budget (or from the consideration of which such committee has been discharged) or unless it is an amendment to such a bill or joint resolution.”.

(8) In section 308(d), in the subsection heading, strike “Scorekeeping Guidelines.—” and insert “SCOREKEEPING GUIDELINES.—”.

(9) In section 310(c)(1)(A)(i) and (ii), strike “under that paragraph by more than” and insert “under that paragraph by more than—”.

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(10) In section 314(d)(2), strike subparagraph (A), redesignate subparagraphs (B) and (C) as subparagraphs (A) and (B) respectively, in subparagraph (A), as redesignated, strike “under subparagraph (A)” and insert “under paragraph (1)”, and in subparagraph (B), as redesignated, strike “under subparagraph (B)” and insert “under subparagraph (A)”.

(11) In section 315, add at the end the following new sentence: “In the case of a reported bill or joint resolution considered pursuant to a special order of business, a point of order under section 303 shall be determined on the basis of the text made in order as an original bill or joint resolution for the purpose of amendment or to the text on which the previous question is ordered directly to passage, as the case may be.”.

(12) In section 401(b)(2), strike “section 302(b)” and insert “section 302(a)”.

(13) In section 401(c), add at the end the following new paragraph:

“(3) In the House of Representatives, subsections (a) and (b) shall not apply to new authority described in those subsections to the extent that a provision in a bill or joint resolution, or an amendment thereto or a conference report thereon, establishes prospectively for a Federal office or position a specified or minimum level of compensation to be funded by annual discretionary appropriations.”.

(14) In section 421(5)(A)(i)(II), strike “subparagraph (B))” and insert “subparagraph (B)”.

(15) In section 505(c), strike “section 406(b)” both places it appears and insert “section 405(b)”.

(16) In section 904(c)(2), strike “258A(b)(3)(C)(I)” and “258(h)(3)” and insert “258A(b)(3)(C)(i)” and “258B(h)(3)”, respectively, and strike “and 314(e)” and insert “314(e), and 314(f)”.

(17) In section 904(d)(3), strike “258A(b)(3)(C)(I)” and “258(h)(3)” and insert “258A(b)(3)(C)(i)” and “258B(h)(3)”, respectively, and strike “and 312(c)” and insert “312(c), 314(e), and 314(f)”.

TITLE II—PREVENTION OF WASTE, FRAUD, AND ABUSE

SEC. 201. IMPROVING THE COLLECTION OF UNEMPLOYMENT INSURANCE OVERPAYMENTS.

(a) IN GENERAL.—Section 303 of the Social Security Act (42 U.S.C. 503) is amended by adding at the end the following:

“(m) In the case of a covered unemployment compensation debt (as defined under section 6402(f)(4) of the Internal Revenue Code of 1986) that remains uncollected as of the date that is 1 year after the debt was finally determined to be due and collected, the State to which such debt is owed shall take action to recover such debt under section 6402(f) of the Internal Revenue Code of 1986.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect upon the date of enactment of this Act.

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SEC. 202. STRENGTHENING MEDICAID THIRD-PARTY LIABILITY.

(a) **PAYMENT FOR PRENATAL AND PREVENTIVE PEDIATRIC CARE AND IN CASES INVOLVING MEDICAL SUPPORT.**—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (E)(i), by inserting before the semicolon at the end the following: “, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services”; and

(2) in subparagraph (F)(i), by striking “30 days after such services are furnished” and inserting “90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.”.

(b) **RECOVERY OF MEDICAID EXPENDITURES FROM BENEFICIARY LIABILITY SETTLEMENTS.**—

(1) **STATE PLAN REQUIREMENTS.**—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(A) in subparagraph (B), by striking “to the extent of such legal liability”; and

(B) in subparagraph (H), by striking “payment by any other party for such health care items or services” and inserting “any payments by such third party”.

(2) **ASSIGNMENT OF RIGHTS OF PAYMENT.**—Section 1912(a)(1)(A) of such Act (42 U.S.C. 1396k(a)(1)(A)) is amended by striking “payment for medical care from any third party” and inserting “any payment from a third party that has a legal liability to pay for care and services available under the plan”.

(3) **LIENS.**—Section 1917(a)(1)(A) of such Act (42 U.S.C. 1396p(a)(1)(A)) is amended to read as follows:

“(A) pursuant to—

“(i) the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

“(ii) rights acquired by or assigned to the State in accordance with section 1902(a)(25)(H) or section 1912(a)(1)(A), or”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on October 1, 2014.

SEC. 203. RESTRICTION ON ACCESS TO THE DEATH MASTER FILE.

(a) **IN GENERAL.**—The Secretary of Commerce shall not disclose to any person information contained on the Death Master File with respect to any deceased individual at any time during the 3-calendar-year period beginning on the date of the individual's death, unless such person is certified under the program established under subsection (b).

(b) **CERTIFICATION PROGRAM.**—

(1) **IN GENERAL.**—The Secretary of Commerce shall establish a program—

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(A) to certify persons who are eligible to access the information described in subsection (a) contained on the Death Master File, and

(B) to perform periodic and unscheduled audits of certified persons to determine the compliance by such certified persons with the requirements of the program.

(2) CERTIFICATION.—A person shall not be certified under the program established under paragraph (1) unless such person certifies that access to the information described in subsection (a) is appropriate because such person—

(A) has—

(i) a legitimate fraud prevention interest, or

(ii) a legitimate business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty, and

(B) has systems, facilities, and procedures in place to safeguard such information, and experience in maintaining the confidentiality, security, and appropriate use of such information, pursuant to requirements similar to the requirements of section 6103(p)(4) of the Internal Revenue Code of 1986, and

(C) agrees to satisfy the requirements of such section 6103(p)(4) as if such section applied to such person.

(3) FEES.—

(A) IN GENERAL.—The Secretary of Commerce shall establish under section 9701 of title 31, United States Code, a program for the charge of fees sufficient to cover (but not to exceed) all costs associated with evaluating applications for certification and auditing, inspecting, and monitoring certified persons under the program. Any fees so collected shall be deposited and credited as offsetting collections to the accounts from which such costs are paid.

(B) REPORT.—The Secretary of Commerce shall report on an annual basis to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives on the total fees collected during the preceding year and the cost of administering the certification program under this subsection for such year.

(c) IMPOSITION OF PENALTY.—

(1) IN GENERAL.—Any person who is certified under the program established under subsection (b), who receives information described in subsection (a), and who during the period of time described in subsection (a)—

(A) discloses such information to any person other than a person who meets the requirements of subparagraphs (A), (B), and (C) of subsection (b)(2),

(B) discloses such information to any person who uses the information for any purpose not listed under subsection (b)(2)(A) or who further discloses the information to a person who does not meet such requirements, or

(C) uses any such information for any purpose not listed under subsection (b)(2)(A), and any person to whom such information is disclosed who further discloses or uses such information as described in the preceding subparagraphs, shall pay a penalty of \$1,000 for each such disclosure or use.

(2) LIMITATION ON PENALTY.—

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(A) **IN GENERAL.**—The total amount of the penalty imposed under this subsection on any person for any calendar year shall not exceed \$250,000.

(B) **EXCEPTION FOR WILLFUL VIOLATIONS.**—Subparagraph (A) shall not apply in the case of violations under paragraph (1) that the Secretary of Commerce determines to be willful or intentional violations.

(d) **DEATH MASTER FILE.**—For purposes of this section, the term “Death Master File” means information on the name, social security account number, date of birth, and date of death of deceased individuals maintained by the Commissioner of Social Security, other than information that was provided to such Commissioner under section 205(r) of the Social Security Act (42 U.S.C. 405(r)).

(e) **EXEMPTION FROM FREEDOM OF INFORMATION ACT REQUIREMENT WITH RESPECT TO CERTAIN RECORDS OF DECEASED INDIVIDUALS.**—

(1) **IN GENERAL.**—No Federal agency shall be compelled to disclose the information described in subsection (a) to any person who is not certified under the program established under subsection (b).

(2) **TREATMENT OF INFORMATION.**—For purposes of section 552 of title 5, United States Code, this section shall be considered a statute described in subsection (b)(3) of such section 552.

(f) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—Except as provided in paragraph (2), this section shall take effect on the date that is 90 days after the date of the enactment of this Act.

(2) **FOIA EXEMPTION.**—Subsection (e) shall take effect on the date of the enactment of this Act.

SEC. 204. IDENTIFICATION OF INMATES REQUESTING OR RECEIVING IMPROPER PAYMENTS.

(a) **INFORMATION PROVIDED TO THE PRISONER UPDATE PROCESSING SYSTEM (PUPS).**—

(1) **SECTION 202(x)(3)(B)(i)(I).**—Section 202(x)(3)(B)(i)(I) of the Social Security Act (42 U.S.C. 402(x)(3)(B)(i)(I)) is amended by—

(A) inserting “first, middle, and last” before “names”;

(B) striking the comma after the words “social security account numbers” and inserting “or taxpayer identification numbers, prison assigned inmate numbers, last known addresses,”;

(C) inserting “dates of release or anticipated dates of release, dates of work release,” before “and, to the extent available”; and

(D) by inserting “and clause (iv) of this subparagraph” after “paragraph (1)”.

(2) **SECTION 1611(e)(1)(I)(i)(I).**—Section 1611(e)(1)(I)(i)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)(i)(I)) is amended by—

(A) inserting “first, middle, and last” before “names”;

(B) striking the comma after the words “social security account numbers” and inserting “or taxpayer identification numbers, prison assigned inmate numbers, last known addresses,”;

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(C) inserting “dates of release or anticipated dates of release, dates of work release,” before “and, to the extent available”; and

(D) by inserting “and clause (iv) of this subparagraph” after “this paragraph”.

(b) **AUTHORITY OF SECRETARY OF THE TREASURY TO ACCESS PUPS.**—

(1) **SECTION 202(x)(3)(B).**—Section 202(x)(3)(B) of the Social Security Act (42 U.S.C. 402(x)(3)(B)) is amended—

(A) in clause (iv), by inserting before the period the following: “, for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs”; and

(B) by adding at the end the following:

“(v)(I) The Commissioner may disclose information received pursuant to this paragraph to any officer, employee, agent, or contractor of the Department of the Treasury whose official duties require such information to assist in the identification, prevention, and recovery of improper payments or in the collection of delinquent debts owed to the United States, including payments certified by the head of an executive, judicial, or legislative paying agency, and payments made to individuals whose eligibility, or continuing eligibility, to participate in a Federal program (including those administered by a State or political subdivision thereof) is being reviewed.

“(II) Notwithstanding the provisions of section 552a of title 5, United States Code, or any other provision of Federal or State law, the Secretary of the Treasury may compare information disclosed under subclause (I) with any other personally identifiable information derived from a Federal system of records or similar records maintained by a Federal contractor, a Federal grantee, or an entity administering a Federal program or activity, and may redisclose such comparison of information to any paying or administering agency and to the head of the Federal Bureau of Prisons and the head of any State agency charged with the administration of prisons with respect to inmates whom the Secretary of the Treasury has determined may have been issued, or facilitated in the issuance of, an improper payment.

“(III) The comparison of information disclosed under subclause (I) shall not be considered a matching program for purposes of section 552a of title 5, United States Code.”

(2) **SECTION 1611(e)(1)(I).**—Section 1611(e)(1)(I) of the Social Security Act (42 U.S.C. 1382(e)(1)(I)) is amended—

(A) in clause (iii), by inserting before the period the following: “, for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs”; and

(B) by adding at the end the following:

“(v)(I) The Commissioner may disclose information received pursuant to this paragraph to any officer, employee, agent, or contractor of the Department of the Treasury whose official duties require such information to assist in the identification, prevention, and recovery of improper payments or in the collection of delinquent

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debts owed to the United States, including payments certified by the head of an executive, judicial, or legislative paying agency, and payments made to individuals whose eligibility, or continuing eligibility, to participate in a Federal program (including those administered by a State or political subdivision thereof) is being reviewed.

“(II) Notwithstanding the provisions of section 552a of title 5, United States Code, or any other provision of Federal or State law, the Secretary of the Treasury may compare information disclosed under subclause (I) with any other personally identifiable information derived from a Federal system of records or similar records maintained by a Federal contractor, a Federal grantee, or an entity administering a Federal program or activity and may redisclose such comparison of information to any paying or administering agency and to the head of the Federal Bureau of Prisons and the head of any State agency charged with the administration of prisons with respect to inmates whom the Secretary of the Treasury has determined may have been issued, or facilitated in the issuance of, an improper payment.

“(III) The comparison of information disclosed under subclause (I) shall not be considered a matching program for purposes of section 552a of title 5, United States Code.”

(c) CONFORMING AMENDMENT TO THE DO NOT PAY INITIATIVE.—Section 5(a)(2) of the Improper Payments Elimination and Recovery Improvement Act of 2012 (31 U.S.C. 3321 note) is amended by adding at the end the following:

“(F) Information regarding incarcerated individuals maintained by the Commissioner of Social Security under sections 202(x) and 1611(e) of the Social Security Act.”.

TITLE III—NATURAL RESOURCES

SEC. 301. ULTRA-DEEPWATER AND UNCONVENTIONAL NATURAL GAS AND OTHER PETROLEUM RESOURCES.

(a) REPEAL.—Subtitle J of title IX of the Energy Policy Act of 2005 (42 U.S.C. 16371 et seq.) is repealed.

(b) RESCISSION.—Any unobligated funds appropriated for carrying out the subtitle repealed by subsection (a) are rescinded.

SEC. 302. AMENDMENT TO THE MINERAL LEASING ACT.

Section 35(b) of the Mineral Leasing Act (30 U.S.C. 191(b)) is amended to read as follows—

“(b) DEDUCTION FOR ADMINISTRATIVE COSTS.—In determining the amount of payments to the States under this section, beginning in fiscal year 2014 and for each year thereafter, the amount of such payments shall be reduced by 2 percent for any administrative or other costs incurred by the United States in carrying out the program authorized by this Act, and the amount of such reduction shall be deposited to miscellaneous receipts of the Treasury.”.

SEC. 303. APPROVAL OF AGREEMENT WITH MEXICO.

The Agreement between the United States of America and the United Mexican States Concerning Transboundary Hydrocarbon Reservoirs in the Gulf of Mexico, signed at Los Cabos, February 20, 2012, is hereby approved.

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SEC. 304. AMENDMENT TO THE OUTER CONTINENTAL SHELF LANDS ACT.

The Outer Continental Shelf Lands Act (43 U.S.C. 1331 et seq.) is amended by adding at the end the following:

“SEC. 32. TRANSBOUNDARY HYDROCARBON AGREEMENTS.

“(a) **AUTHORIZATION.**—After the date of enactment of the Bipartisan Budget Act of 2013, the Secretary may implement the terms of any transboundary hydrocarbon agreement for the management of transboundary hydrocarbon reservoirs entered into by the President and approved by Congress. In implementing such an agreement, the Secretary shall protect the interests of the United States to promote domestic job creation and ensure the expeditious and orderly development and conservation of domestic mineral resources in accordance with all applicable United States laws governing the exploration, development, and production of hydrocarbon resources on the Outer Continental Shelf.

“(b) **SUBMISSION TO CONGRESS.**—

“(1) **IN GENERAL.**—No later than 180 days after all parties to a transboundary hydrocarbon agreement have agreed to its terms, a transboundary hydrocarbon agreement that does not constitute a treaty in the judgment of the President shall be submitted by the Secretary to—

“(A) the Speaker of the House of Representatives;

“(B) the Majority Leader of the Senate;

“(C) the Chair of the Committee on Natural Resources of the House of Representatives; and

“(D) the Chair of the Committee on Energy and Natural Resources of the Senate.

“(2) **CONTENTS OF SUBMISSION.**—The submission shall include—

“(A) any amendments to this Act or other Federal law necessary to implement the agreement;

“(B) an analysis of the economic impacts such agreement and any amendments necessitated by the agreement will have on domestic exploration, development, and production of hydrocarbon resources on the Outer Continental Shelf; and

“(C) a detailed description of any regulations expected to be issued by the Secretary to implement the agreement.

“(c) **IMPLEMENTATION OF SPECIFIC TRANSBOUNDARY AGREEMENT WITH MEXICO.**—The Secretary may take actions as necessary to implement the terms of the Agreement between the United States of America and the United Mexican States Concerning Transboundary Hydrocarbon Reservoirs in the Gulf of Mexico, signed at Los Cabos, February 20, 2012, including—

“(1) approving unitization agreements and related arrangements for the exploration, development, or production of oil and natural gas from transboundary reservoirs or geological structures;

“(2) making available, in the limited manner necessary under the agreement and subject to the protections of confidentiality provided by the agreement, information relating to the exploration, development, and production of oil and natural gas from a transboundary reservoir or geological structure that may be considered confidential, privileged, or proprietary information under law;

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"(3) taking actions consistent with an expert determination under the agreement; and

"(4) ensuring only appropriate inspection staff at the Bureau of Safety and Environmental Enforcement or other Federal agency personnel designated by the Bureau, the operator, or the lessee have authority to stop work on any installation or other device or vessel permanently or temporarily attached to the seabed of the United States that may be erected thereon for the purpose of resource exploration, development or production activities as approved by the Secretary.

"(d) SAVINGS PROVISIONS.—Nothing in this section shall be construed—

"(1) to authorize the Secretary to participate in any negotiations, conferences, or consultations with Cuba regarding exploration, development, or production of hydrocarbon resources in the Gulf of Mexico along the United States maritime border with Cuba or the area known by the Department of the Interior as the 'Eastern Gap'; or

"(2) as affecting the sovereign rights and the jurisdiction that the United States has under international law over the Outer Continental Shelf that appertains to it."

SEC. 305. FEDERAL OIL AND GAS ROYALTY PREPAYMENT CAP.

(a) IN GENERAL.—Section 111(i) of the Federal Oil and Gas Royalty Management Act of 1982 (30 U.S.C. 1721(i)) is amended by striking "(i) Upon" and all that follows through "For purposes" and inserting the following:

"(i) LIMITATION ON INTEREST.—

"(1) IN GENERAL.—Interest shall not be paid on any excessive overpayment.

"(2) EXCESSIVE OVERPAYMENT DEFINED.—For purposes"

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on July 1, 2014.

SEC. 306. STRATEGIC PETROLEUM RESERVE.

(a) REPEAL OF AUTHORITY TO ACQUIRE IN-KIND ROYALTY CRUDE OIL.—Section 160(a) of the Energy Policy and Conservation Act (42 U.S.C. 6240(a)) is amended to read as follows:

"(a) The Secretary may acquire, place in storage, transport, or exchange petroleum products acquired by purchase or exchange."

(b) RESCISSION OF FUNDS.—Any unobligated balances available in the SPR Petroleum Account in the Treasury on the date of enactment of this section are permanently rescinded.

**TITLE IV—FEDERAL CIVILIAN AND
MILITARY RETIREMENT**

**SEC. 401. INCREASE IN CONTRIBUTIONS TO FEDERAL EMPLOYEES
RETIREMENT SYSTEM FOR NEW EMPLOYEES.**

(a) DEFINITION.—

(1) IN GENERAL.—Section 8401 of title 5, United States Code, is amended—

(A) in paragraph (36), by striking "and" at the end;

(B) in paragraph (37), by striking the period and inserting "; and"; and

(C) by adding at the end the following:

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“(38) the term ‘further revised annuity employee’ means any individual who—

“(A) on December 31, 2013—

“(i) is not an employee or Member covered under this chapter;

“(ii) is not performing civilian service which is creditable service under section 8411; and

“(iii) has less than 5 years of creditable civilian service under section 8411; and

“(B) after December 31, 2013, becomes employed as an employee or becomes a Member covered under this chapter performing service which is creditable service under section 8411.”

(2) TECHNICAL AMENDMENT.—Section 8401(37)(B) of title 5, United States Code, is amended by inserting “and before January 1, 2014,” after “after December 31, 2012,”.

(b) INCREASE IN INDIVIDUAL CONTRIBUTIONS.—Section 8422(a)(3) of title 5, United States Code, is amended—

(1) in subparagraph (A), by inserting “or further revised annuity employees” after “revised annuity employees”; and

(2) by adding at the end the following:

“(C) The applicable percentage under this paragraph for civilian service by further revised annuity employees shall be as follows:

“Employee	10.6	After December 31, 2013.
Congressional em- ployee	10.6	After December 31, 2013.
Member	10.6	After December 31, 2013.
Law enforcement offi- cer, firefighter, mem- ber of the Capitol Po- lice, member of the Supreme Court Po- lice, or air traffic con- troller	11.1	After December 31, 2013.
Nuclear materials cou- rier	11.1	After December 31, 2013.
Customs and border protection officer	11.1	After December 31, 2013.”

(c) GOVERNMENT CONTRIBUTIONS.—Section 8423(a)(2) of title 5, United States Code, is amended—

(1) by striking “(2)” and inserting “(2)(A)”; and

(2) by adding at the end the following:

“(B)(i) Subject to clauses (ii) and (iii), for purposes of any period in any year beginning after December 31, 2013, the normal-cost percentage under this subsection shall be determined and applied as if section 401(b) of the Bipartisan Budget Act of 2013 had not been enacted.

“(ii) Any contributions under this subsection in excess of the amounts which (but for clause (i)) would otherwise have been payable shall be applied toward reducing the unfunded liability of the Civil Service Retirement System.

“(iii) After the unfunded liability of the Civil Service Retirement System has been eliminated, as determined by the Office, Government contributions under this subsection shall be determined and made disregarding this subparagraph.

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“(iv) The preceding provisions of this subparagraph shall be disregarded for purposes of determining the contributions payable by the United States Postal Service and the Postal Regulatory Commission.”

(d) ANNUITY CALCULATION.—Section 8415(d) of title 5, United States Code, is amended by inserting “or a further revised annuity employee” after “a revised annuity employee”.

SEC. 402. FOREIGN SERVICE PENSION SYSTEM.

(a) DEFINITION.—

(1) IN GENERAL.—Section 852 of the Foreign Service Act of 1980 (22 U.S.C. 4071a) is amended—

(A) by redesignating paragraphs (8), (9), and (10) as paragraphs (9), (10), and (11), respectively; and

(B) by inserting after paragraph (7) the following:

“(8) the term ‘further revised annuity participant’ means any individual who—

“(A) on December 31, 2013—

“(i) is not a participant;

“(ii) is not performing service which is creditable service under section 854; and

“(iii) has less than 5 years creditable service under section 854; and

“(B) after December 31, 2013, becomes a participant performing service which is creditable service under section 854.”

(2) TECHNICAL AMENDMENT.—Section 852(7)(B) of the Foreign Service Act of 1980 (22 U.S.C. 4071a(7)(B)) is amended by inserting “and before January 1, 2014,” after “after December 31, 2012.”

(b) DEDUCTIONS AND WITHHOLDINGS FROM PAY.—Section 856(a)(2) of the Foreign Service Act of 1980 (22 U.S.C. 4071e(a)(2)) is amended—

(1) in subparagraph (A), by inserting “or a further revised annuity participant” after “revised annuity participant”; and

(2) by adding at the end the following:

“(C) The applicable percentage for a further revised annuity participant shall be as follows:

“11.15 After December 31, 2013.”.

(c) GOVERNMENT CONTRIBUTIONS.—Section 857 of the Foreign Service Act of 1980 (22 U.S.C. 4071f) is amended by adding at the end the following:

“(c)(1) Subject to paragraphs (2) and (3), for purposes of any period in any year beginning after December 31, 2013, the normal-cost percentage under this section shall be determined and applied as if section 402(b) of the Bipartisan Budget Act of 2013 had not been enacted.

“(2) Any contributions under this section in excess of the amounts which (but for paragraph (1)) would otherwise have been payable shall be applied toward reducing the unfunded liability of the Foreign Service Retirement and Disability System.

“(3) After the unfunded liability of the Foreign Service Retirement and Disability System has been eliminated, as determined by the Secretary of State, Government contributions under this section shall be determined and made disregarding this subsection.”.

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SEC. 403. ANNUAL ADJUSTMENT OF RETIRED PAY AND RETAINER PAY AMOUNTS FOR RETIRED MEMBERS OF THE ARMED FORCES UNDER AGE 62.

(a) **CPI MINUS ONE PERCENT.**—Section 1401a(b) of title 10, United States Code, is amended—

(1) in paragraph (1), by striking “paragraphs (2) and (3)” and inserting “paragraph (2), (3), or (4)”; and

(2) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively; and

(3) by inserting after paragraph (3) the following new paragraph (4):

“(4) **REDUCED PERCENTAGE FOR RETIRED MEMBERS UNDER AGE 62.**—

“(A) **IN GENERAL.**—Effective on December 1 of each year, the retired pay of each member and former member under 62 years of age entitled to that pay shall be adjusted in accordance with this paragraph instead of paragraph (2) or (3).

“(B) **CPI MINUS ONE.**—If the percent determined under paragraph (2) is greater than 1 percent, the Secretary shall increase the retired pay of each member and former member by the difference between—

“(i) the percent determined under paragraph (2);

and

“(ii) 1 percent.

“(C) **NO NEGATIVE ADJUSTMENT.**—If the percent determined under paragraph (2) is equal to or less than 1 percent, the Secretary shall not increase the retired pay of members and former members under this paragraph.

“(D) **REVISED ADJUSTMENT UPON REACHING AGE 62.**—When a member or former member whose retired pay has been subject to adjustment under this paragraph becomes 62 years of age, the Secretary of Defense shall recompute the retired pay of the member or former member, to be effective on the date of the next adjustment of retired pay under this subsection, so as to be the amount equal to the amount of retired pay to which the member or former member would be entitled on that date if increases in the retired pay of the member or former member had been computed as provided in paragraph (2) or as specified in section 1410 of this title, as applicable, rather than this paragraph.

“(E) **INAPPLICABILITY OF CATCH-UP RULE.**—Paragraph (5) shall not apply in the case of adjustments made, or not made, as a result of application of this paragraph.”.

(b) **RESTORAL OF FULL RETIREMENT AMOUNT AT AGE 62.**—Section 1410(1) of title 10, United States Code, is amended by striking “paragraph (3)” and inserting “paragraph (3) or (4)”.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall take effect on December 1, 2015.

TITLE V—HIGHER EDUCATION

SEC. 501. DEFAULT REDUCTION PROGRAM.

Effective July 1, 2014, section 428F(a)(1) of the Higher Education Act of 1965 (20 U.S.C. 1078–6(a)(1)) is amended—

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(1) in subparagraph (A), by striking clause (ii) and inserting the following:

“(ii) beginning July 1, 2014, assign the loan to the Secretary if the guaranty agency has been unable to sell the loan under clause (i).”; and

(2) in subparagraph (D), by striking clause (i) and inserting the following:

“(i) the guaranty agency—

“(I) shall, in the case of a sale made on or after July 1, 2014, repay the Secretary 100 percent of the amount of the principal balance outstanding at the time of such sale, multiplied by the reinsurance percentage in effect when payment under the guaranty agreement was made with respect to the loan; and

“(II) may, in the case of a sale made on or after July 1, 2014, in order to defray collection costs—

“(aa) charge to the borrower an amount not to exceed 16 percent of the outstanding principal and interest at the time of the loan sale; and

“(bb) retain such amount from the proceeds of the loan sale; and”.

SEC. 502. ELIMINATION OF NONPROFIT SERVICING CONTRACTS.

The Higher Education Act of 1965 (20 U.S.C. 1001 et seq.) is amended—

(1) in section 456 (20 U.S.C. 1087f)—

(A) in subsection (a), by striking paragraph (4); and

(B) by striking subsection (c); and

(2) in section 458(a) (20 U.S.C. 1087h(a)), by striking paragraph (2).

TITLE VI—TRANSPORTATION

SEC. 601. AVIATION SECURITY SERVICE FEES.

(a) AIR CARRIER FEES.—

(1) REPEAL.—Section 44940(a)(2) of title 49, United States Code, is repealed.

(2) CONFORMING AMENDMENT.—Section 44940(d)(1) of such title is amended by striking “, and may impose a fee under subsection (a)(2).”.

(3) EFFECTIVE DATE.—The repeal made by paragraph (1) and the amendment made by paragraph (2) shall each take effect on October 1, 2014.

(b) RESTRUCTURING OF PASSENGER FEE.—Section 44940(c) of such title is amended to read as follows:

“(c) LIMITATION ON FEE.—Fees imposed under subsection (a)(1) shall be \$5.60 per one-way trip in air transportation or intrastate air transportation that originates at an airport in the United States.”.

(c) DEPOSIT OF RECEIPTS IN GENERAL FUND.—Section 44940(i) of such title is amended to read as follows:

“(i) DEPOSIT OF RECEIPTS IN GENERAL FUND.—

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“(1) IN GENERAL.—Beginning in fiscal year 2014, out of fees received in a fiscal year under subsection (a)(1), after amounts are made available in the fiscal year under section 44923(h), the next funds derived from such fees in the fiscal year, in the amount specified for the fiscal year in paragraph (4), shall be credited as offsetting receipts and deposited in the general fund of the Treasury.

“(2) FEE LEVELS.—The Secretary of Homeland Security shall impose the fee authorized by subsection (a)(1) so as to collect in a fiscal year at least the amount specified in paragraph (4) for the fiscal year for making deposits under paragraph (1).

“(3) RELATIONSHIP TO OTHER PROVISIONS.—Subsections (b) and (f) shall not apply to amounts to be used for making deposits under this subsection.

“(4) FISCAL YEAR AMOUNTS.—For purposes of paragraphs (1) and (2), the fiscal year amounts are as follows:

“(A) \$390,000,000 for fiscal year 2014.

“(B) \$1,190,000,000 for fiscal year 2015.

“(C) \$1,250,000,000 for fiscal year 2016.

“(D) \$1,280,000,000 for fiscal year 2017.

“(E) \$1,320,000,000 for fiscal year 2018.

“(F) \$1,360,000,000 for fiscal year 2019.

“(G) \$1,400,000,000 for fiscal year 2020.

“(H) \$1,440,000,000 for fiscal year 2021.

“(I) \$1,480,000,000 for fiscal year 2022.

“(J) \$1,520,000,000 for fiscal year 2023.”.

(d) IMPOSITION OF FEE INCREASE.—The Secretary of Homeland Security shall implement the fee increase authorized by the amendment made by subsection (b)—

(1) beginning on July 1, 2014; and

(2) through the publication of notice of such fee in the Federal Register, notwithstanding section 9701 of title 31, United States Code, and the procedural requirements of section 553 of title 5, United States Code.

(e) CONTINUED AVAILABILITY OF EXISTING BALANCES.—The amendments made by this section shall not affect the availability of funds made available under section 44940(i) of title 49, United States Code, before the date of enactment of this Act.

SEC. 602. TRANSPORTATION COST REIMBURSEMENT.

(a) REPEAL.—Sections 55316 and 55317 of chapter 553 of title 46, United States Code, are repealed.

(b) TABLE OF SECTIONS AMENDMENT.—The table of sections at the beginning of chapter 553 of title 46, United States Code, is amended by striking the items relating to section 55316 and 55317.

SEC. 603. STERILE AREAS AT AIRPORTS.

Section 44903 of title 49, United States Code, is amended by adding at the end the following:

“(n) PASSENGER EXIT POINTS FROM STERILE AREA.—

“(1) IN GENERAL.—The Secretary of Homeland Security shall ensure that the Transportation Security Administration is responsible for monitoring passenger exit points from the sterile area of airports at which the Transportation Security Administration provided such monitoring as of December 1, 2013.

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"(2) **STERILE AREA DEFINED.**—In this section, the term 'sterile area' has the meaning given that term in section 1540.5 of title 49, Code of Federal Regulations (or any corresponding similar regulation or ruling).".

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. EXTENSION OF CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended—

(1) in subparagraph (A), by striking "October 22, 2021" and inserting "September 30, 2023"; and

(2) in subparagraph (B)(i), by striking "October 29, 2021" and inserting "September 30, 2023".

SEC. 702. LIMITATION ON ALLOWABLE GOVERNMENT CONTRACTOR COMPENSATION COSTS.

(a) **LIMITATION.**—

(1) **CIVILIAN CONTRACTS.**—Section 4304(a)(16) of title 41, United States Code, is amended to read as follows:

"(16) Costs of compensation of contractor and subcontractor employees for a fiscal year, regardless of the contract funding source, to the extent that such compensation exceeds \$487,000 per year, adjusted annually to reflect the change in the Employment Cost Index for all workers, as calculated by the Bureau of Labor Statistics, except that the head of an executive agency may establish one or more narrowly targeted exceptions for scientists, engineers, or other specialists upon a determination that such exceptions are needed to ensure that the executive agency has continued access to needed skills and capabilities."

(2) **DEFENSE CONTRACTS.**—Section 2324(e)(1)(P) of title 10, United States Code, is amended to read as follows:

"(P) Costs of compensation of contractor and subcontractor employees for a fiscal year, regardless of the contract funding source, to the extent that such compensation exceeds \$487,000 per year, adjusted annually to reflect the change in the Employment Cost Index for all workers, as calculated by the Bureau of Labor Statistics, except that the head of an executive agency may establish one or more narrowly targeted exceptions for scientists, engineers, or other specialists upon a determination that such exceptions are needed to ensure that the executive agency has continued access to needed skills and capabilities."

(b) **CONFORMING AMENDMENTS.**—

(1) **REPEAL.**—Section 1127 of title 41, United States Code, is hereby repealed.

(2) **CLERICAL AMENDMENT.**—The table of sections at the beginning of chapter 11 of title 41, United States Code, is amended by striking the item relating to section 1127.

(c) **APPLICABILITY.**—This section and the amendments made by this section shall apply only with respect to costs of compensation incurred under contracts entered into on or after the date that is 180 days after the date of the enactment of this Act.

(d) **REPORTS.**—

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(1) IN GENERAL.—Not later than 60 days after the end of each fiscal year, the Director of the Office of Management and Budget shall submit a report on contractor compensation to—

- (A) the Committee on Armed Services of the Senate;
- (B) the Committee on Armed Services of the House of Representatives;
- (C) the Committee on Homeland Security and Governmental Affairs of the Senate;
- (D) the Committee on Oversight and Government Reform of the House of Representatives;
- (E) the Committee on Appropriations of the Senate; and
- (F) the Committee on Appropriations of the House of Representatives.

(2) ELEMENTS.—The report required under paragraph (1) shall include—

- (A) the total number of contractor employees, by executive agency, in the narrowly targeted exception positions described under subsection (a) during the preceding fiscal year;
- (B) the taxpayer-funded compensation amounts received by each contractor employee in a narrowly targeted exception position during such fiscal year; and
- (C) the duties and services performed by contractor employees in the narrowly targeted exception positions during such fiscal year.

(e) REVIEW.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Defense and the Director of the Office of Management and Budget shall report to Congress on alternative benchmarks and industry standards for compensation, including whether any such benchmarks or standards would provide a more appropriate measure of allowable compensation for the purposes of section 2324(e)(1)(P) of title 10, United States Code, and section 4304(a)(16) of title 41, United States Code, as amended by this Act.

SEC. 703. PENSION BENEFIT GUARANTY CORPORATION PREMIUM RATE INCREASES.

(a) FLAT-RATE PREMIUM INCREASES.—Section 4006(a)(3)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1306(a)(3)(A)(i)) is amended—

- (1) in subclause (II), by striking “and” at the end;
- (2) in subclause (III), by inserting “and before January 1, 2015,” after “December 31, 2013”; and
- (3) by inserting after subclause (III) the following:
 - “(IV) for plan years beginning after December 31, 2014, and before January 1, 2016, \$57; and
 - “(V) for plan years beginning after December 31, 2015, and before January 1, 2017, \$64.”

(b) FLAT-RATE PREMIUM RATE INDEXED TO WAGES.—

(1) IN GENERAL.—Section 4006(a)(3) of such Act (29 U.S.C. 1306(a)(3)) is amended—

- (A) by redesignating subparagraphs (G) through (J) as subparagraphs (H) through (K), respectively; and
- (B) by inserting after subparagraph (F) the following:

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“(G) For each plan year beginning in a calendar year after 2016, there shall be substituted for the premium rate specified in clause (i) of subparagraph (A) an amount equal to the greater of—

“(i) the product derived by multiplying the premium rate specified in clause (i) of subparagraph (A) by the ratio of—

“(I) the national average wage index (as defined in section 209(k)(1) of the Social Security Act) for the first of the 2 calendar years preceding the calendar year in which such plan year begins, to

“(II) the national average wage index (as so defined) for 2014; and

“(ii) the premium rate in effect under clause (i) of subparagraph (A) for plan years beginning in the preceding calendar year.

If the amount determined under this subparagraph is not a multiple of \$1, such product shall be rounded to the nearest multiple of \$1.”.

(2) CONFORMING AMENDMENTS.—Section 4006(a)(3)(F) of such Act (29 U.S.C. 1306(a)(3)(F)) is amended—

(A) in the matter before clause (i), by inserting “and before 2013” after “after 2006”; and

(B) in the flush text following clause (ii), by striking the second sentence.

(c) VARIABLE RATE PREMIUM INCREASES.—

(1) IN GENERAL.—Section 4006(a)(8)(C) of such Act (29 U.S.C. 1306(a)(8)(C)) is amended—

(A) in clause (i), by striking “and” at the end;

(B) in clause (ii), by striking “\$5.” and inserting “\$10; and”; and

(C) by adding at the end the following:

“(iii) in the case of plan years beginning in calendar year 2016, by \$5.”.

(2) CONFORMING AMENDMENTS.—Section 4006(a)(8) of such Act (29 U.S.C. 1306(a)(8)) is amended—

(A) in subparagraph (A)—

(i) in clause (ii), by striking “and” at the end;

(ii) in clause (iii), by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following:

“(iv) for plan years beginning after calendar year 2016, the amount in effect for plan years beginning in 2016 (determined after application of subparagraph (C)).”; and

(B) in subparagraph (D)—

(i) in clause (ii), by striking “and” at the end;

(ii) in clause (iii), by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following:

“(iv) 2014, in the case of plan years beginning after calendar year 2016.”.

(d) INCREASE IN VARIABLE RATE PREMIUM CAP.—

(1) IN GENERAL.—Section 4006(a)(3)(E)(i) of such Act (29 U.S.C. 1306(a)(3)(E)(i)) is amended—

(A) in subclause (I), by striking “and” at the end;

(B) in subclause (II)—

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- (i) by inserting “and before 2016” after “2012”; and
- (ii) by striking the period at the end and inserting “and”; and

(C) by adding at the end the following:

“(III) in the case of plan years beginning in a calendar year after 2015, shall not exceed \$500.”

(2) INDEX TO WAGES.—Section 4006(a)(3) of such Act (29 U.S.C. 1306(a)(3)) is amended—

(A) in subparagraph (K) (as redesignated by subsection (b)(1)(A)), by inserting “and before 2016” after “2013”; and

(B) by inserting at the end the following:

“(L) For each plan year beginning in a calendar year after 2016, there shall be substituted for the dollar amount specified in subclause (III) of subparagraph (E)(i) an amount equal to the greater of—

“(i) the product derived by multiplying such dollar amount by the ratio of—

“(I) the national average wage index (as defined in section 209(k)(1) of the Social Security Act) for the first of the 2 calendar years preceding the calendar year in which such plan year begins, to

“(II) the national average wage index (as so defined) for 2014; and

“(ii) such dollar amount for plan years beginning in the preceding calendar year.

If the amount determined under this subparagraph is not a multiple of \$1, such product shall be rounded to the nearest multiple of \$1.”

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2013.

SEC. 704. CANCELLATION OF UNOBLIGATED BALANCES.

(a) DEPARTMENT OF JUSTICE ASSETS FORFEITURE FUND.—Effective on the date of enactment of this Act, of the unobligated balances available under the Department of Justice Assets Forfeiture Fund, \$693,000,000 are permanently cancelled.

(b) TREASURY FORFEITURE FUND.—Effective on the date of enactment of this Act, of the unobligated balances available under the Department of the Treasury Forfeiture Fund, \$867,000,000, are permanently cancelled.

SEC. 705. CONSERVATION PLANNING TECHNICAL ASSISTANCE USER FEES.

(a) USER FEES AUTHORIZED.—Section 3 of the Soil Conservation and Domestic Allotment Act (16 U.S.C. 590c) is amended—

(1) by striking “require—” and inserting “require the following:”;

(2) in paragraph (1), by striking the semicolon at the end and inserting a period;

(3) in paragraph (2), by striking “; and” at the end and inserting a period; and

(4) by adding at the end the following:

“(4)(A) The payment of user fees for conservation planning technical assistance if the Secretary determines that the fees, subject to subparagraph (B), are—

“(i) reasonable and appropriate;

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"(ii) assessed for conservation planning technical assistance resulting in the development of a conservation plan; and

"(iii) assessed based on the size of the land or the complexity of the resource issues involved.

"(B) Fees under subparagraph (A) may not exceed \$150 per conservation plan for which technical assistance is provided.

"(C) The Secretary may waive fees otherwise required under subparagraph (A) in the case of conservation planning technical assistance provided—

"(i) to beginning farmers or ranchers (as defined in section 343(a) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1991(a));

"(ii) to limited resource farmers or ranchers (as defined by the Secretary);

"(iii) to socially disadvantaged farmers or ranchers (as defined in section 355(e) of the Consolidated Farm and Rural Development Act (7 U.S.C. 2003(e));

"(iv) to qualify for an exemption from ineligibility under section 1212 of the Food Security Act of 1985 (16 U.S.C. 3812); or

"(v) to comply with Federal, State, or local regulatory requirements."

(b) CONSERVATION TECHNICAL ASSISTANCE FUND.—Section 6 of the Soil Conservation and Domestic Allotment Act (16 U.S.C. 590f) is amended—

(1) by striking "SEC. 6." and all that follows through "There are hereby authorized" and inserting the following:

"SEC. 6. AUTHORIZATION OF APPROPRIATIONS AND CONSERVATION TECHNICAL ASSISTANCE FUNDS.

"(a) AUTHORIZATION OF APPROPRIATIONS.—There is authorized"; and

(2) by adding at the end the following:

"(b) CONSERVATION TECHNICAL ASSISTANCE FUND.—

"(1) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the 'Conservation Technical Assistance Fund' (referred to in this subsection as the 'Fund'), to be administered by the Secretary of Agriculture.

"(2) DEPOSITS.—An amount equal to the amounts collected as fees under section 3(4) and late payments, interest, and such other amounts as are authorized to be collected pursuant to section 3717 of title 31, United States Code, shall be deposited in the Fund.

"(3) AVAILABILITY.—Amounts in the Fund shall—

"(A) only be available to the extent and in the amount provided in advance in appropriations Acts;

"(B) be used for the costs of carrying out this Act;

and

"(C) remain available until expended."

SEC. 706. SELF PLUS ONE COVERAGE.

(a) ELECTION OF COVERAGE.—Section 8905 of title 5, United States Code, is amended—

(1) by striking subsection (a) and inserting the following:

"(a) An employee may enroll in an approved health benefits plan described in section 8903 or 8903a—

"(1) as an individual;

"(2) for self plus one; or

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“(3) for self and family.”;

(2) in subsection (c)—

(A) in paragraph (1), in the matter following subparagraph (B), by inserting “for self plus one or” before “self and family as provided in paragraph (2) of this subsection”; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting “for self plus one or” before “for self and family”; and

(ii) in subparagraph (B), by inserting “(or, in the case of self plus one coverage, not more than 1 such child)” after “adopted children”;

(3) in subsection (e), by striking “or each spouse may enroll as an individual” and inserting “or for a self plus one enrollment that covers the spouse, or each spouse may enroll as an individual or for a self plus one enrollment that does not cover the other spouse or a child who is covered under the enrollment of the other spouse”; and

(4) in subsection (h)—

(A) by striking “self and family enrollment” each place it appears and inserting “self plus one or self and family enrollment, as necessary to provide health insurance coverage for each child who is covered under the order,”;

(B) by striking “a child” each place it appears and inserting “1 or more children”;

(C) by striking “the child resides” each place it appears and inserting “the child or children reside”;

(D) in paragraph (1), by striking “self and family coverage” each place it appears and inserting “self plus one or self and family coverage, as necessary to provide health insurance coverage for each child who is covered under the order,”; and

(E) in paragraph (3), by striking “the child continues” and inserting “the child or children continue”.

(b) CONTINUED COVERAGE.—Section 8905a of title 5, United States Code, is amended—

(1) in subsection (d)(3)(A), by inserting “for self plus one or” before “for self and family”; and

(2) in subsection (f)(3)(A), by striking “for self and family based on such person’s separation from service” and inserting “based on such person’s separation from service under a self plus one enrollment that covered the individual or under a self and family enrollment”.

(c) CONTRIBUTIONS.—Section 8906(a)(1) of title 5, United States Code is amended—

(1) in subparagraph (A), by striking at the end “and”;

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following:

“(B) enrollments under this chapter for self plus one; and”.

(d) WEIGHTED AVERAGE FOR FIRST YEAR.—For the first contract year for which an employee may enroll for self plus one coverage under chapter 89 of title 5, United States Code, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect for the contract

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year for enrollments for self plus one under such chapter based on an actuarial analysis.

DIVISION B—MEDICARE AND OTHER HEALTH PROVISIONS

SEC. 1001. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This division may be cited as the “Pathway for SGR Reform Act of 2013”.

(b) **TABLE OF CONTENTS.**—The table of contents of this division is as follows:

DIVISION B—MEDICARE AND OTHER HEALTH PROVISIONS

Sec. 1001. Short title; table of contents.

Sec. 1002. Findings; purpose statement.

TITLE I—MEDICARE EXTENDERS

Sec. 1101. Physician payment update.

Sec. 1102. Extension of work GPCI floor.

Sec. 1103. Extension of therapy cap exceptions process.

Sec. 1104. Extension of ambulance add-ons.

Sec. 1105. Medicare inpatient hospital payment adjustment for low-volume hospitals.

Sec. 1106. Medicare-dependent hospital (MDH) program.

Sec. 1107. 1-year extension of authorization for special needs plans.

Sec. 1108. 1-year extension of Medicare reasonable cost contracts.

Sec. 1109. Extension of existing funding for contract with consensus-based entity.

Sec. 1110. Extension of funding outreach and assistance for low-income programs.

TITLE II—OTHER HEALTH PROVISIONS

Sec. 1201. Extension of the qualifying individual (QI) program.

Sec. 1202. Temporary extension of transitional medical assistance (TMA).

Sec. 1203. Extension of funding for family-to-family health information centers.

Sec. 1204. Delay of reductions to Medicaid DSH allotments.

Sec. 1205. Realignment of the Medicare sequester for fiscal year 2023.

Sec. 1206. Payment for inpatient services in long-term care hospitals (LTCHs).

SEC. 1002. FINDINGS; PURPOSE STATEMENT.

In order to support the provision of quality care for our nation’s seniors, Congress finds it appropriate to reform physician reimbursements under the Medicare program. SGR reform legislation provides such an opportunity, but not until next year. In order to facilitate such reform, Congress finds that the Centers for Medicare & Medicaid Services should continue to focus its efforts on the following areas:

(1) **SIMPLIFY AND REDUCE ADMINISTRATIVE BURDEN ON PHYSICIANS.**—The application and assessment of measures and other activities under SGR reform should be facilitated by the Centers for Medicare and Medicaid Services (CMS) in a way that accounts for the administrative burden such measurement places on physicians. Therefore, the Congress encourages CMS to identify and implement, to the extent practicable, mechanisms to ensure that the application and assessment of measures be coordinated across programs.

(2) **TIMELY FEEDBACK FOR PHYSICIANS.**—In order for measure and assessment programs to encourage the highest quality care for Medicare seniors, the Congress finds it critical that CMS provide physicians with feedback on performance in as close to real time as possible. Such timely feedback will ensure that physicians can excel under a system of meaningful measurement.

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(3) ENCOURAGE DEVELOPMENT OF NEW MODELS.—There is great need to test alternatives to Fee-For-Service reimbursement in the Medicare program. One option is the promotion and adoption of new models of care for physicians. To date, there has been significant development and testing of models for primary care. Congress supports these efforts and encourages them to continue in the future. Congress also encourages the development and testing of models of specialty care.

TITLE I—MEDICARE EXTENDERS

SEC. 1101. PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 10 1395w-4(d)) is amended by adding at the end the following new paragraph:

“(15) UPDATE FOR JANUARY THROUGH MARCH OF 2014.—

“(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), and (14)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2014 for the period beginning on January 1, 2014, and ending on March 31, 2014, the update to the single conversion factor shall be 0.5 percent.

“(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2014 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on April 1, 2014, and ending on December 31, 2014, and for 2015 and subsequent years as if subparagraph (A) had never applied.”.

SEC. 1102. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “January 1, 2014” and inserting “April 1, 2014”.

SEC. 1103. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (5)(A), in the first sentence, by striking “December 31, 2013” and inserting “March 31, 2014”; and

(2) in paragraph (6)(A)—

(A) by striking “December 31, 2013” and inserting “March 31, 2014”; and

(B) by striking “or 2013” and inserting “, 2013, or the first three months of 2014”.

SEC. 1104. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i), by striking “January 1, 2014” and inserting “April 1, 2014”; and

(2) in each of clauses (i) and (ii), by striking “January 1, 2014” and inserting “April 1, 2014” each place it appears.

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking “January 1, 2014” and inserting “April 1, 2014”.

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SEC. 1105. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking “fiscal year 2014 and subsequent fiscal years” and inserting “the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years”;

(2) in subparagraph (C)(i)—

(A) by inserting “and the portion of fiscal year 2014 before” after “and 2013,” each place it appears; and

(B) by inserting “or portion of fiscal year” after “during the fiscal year”; and

(3) in subparagraph (D)—

(A) by inserting “and the portion of fiscal year 2014 before April 1, 2014,” after “and 2013,”; and

(B) by inserting “or the portion of fiscal year” after “in the fiscal year”.

SEC. 1106. MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking “October 1, 2013” and inserting “April 1, 2014”; and

(2) in clause (ii)(II), by striking “October 1, 2013” and inserting “April 1, 2014”.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “October 1, 2013” and inserting “April 1, 2014”; and

(B) in clause (iv), by inserting “and the portion of fiscal year 2014 before April 1, 2014” after “through fiscal year 2013”.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking “through fiscal year 2013” and inserting “through the first 2 quarters of fiscal year 2014”.

SEC. 1107. 1-YEAR EXTENSION OF AUTHORIZATION FOR SPECIAL NEEDS PLANS.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w-28(f)(1)) is amended by striking “2015” and inserting “2016”.

SEC. 1108. 1-YEAR EXTENSION OF MEDICARE REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking “January 1, 2014” and inserting “January 1, 2015”.

SEC. 1109. EXTENSION OF EXISTING FUNDING FOR CONTRACT WITH CONSENSUS-BASED ENTITY.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by adding at the end the following new sentence: “Amounts transferred under the preceding sentence shall remain available until expended.”.

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SEC. 1110. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) **ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.**—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act Public Law 111–148) and section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), is amended—

- (1) in clause (ii), by striking “and” at the end;
- (2) in clause (iii), by striking the period at the end and inserting “; and”; and
- (3) by inserting after clause (iii) the following new clause:
“(iv) for the portion of fiscal year 2014 before April 1, 2014, of \$3,750,000.”.

(b) **ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.**—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

- (1) in clause (ii), by striking “and” at the end;
- (2) in clause (iii), by striking the period at the end and inserting “; and”; and
- (3) by inserting after clause (iii) the following new clause:
“(iv) for the portion of fiscal year 2014 before April 1, 2014, of \$3,750,000.”.

(c) **ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.**—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

- (1) in clause (ii), by striking “and” at the end;
- (2) in clause (iii), by striking the period at the end and inserting “; and”; and
- (3) by inserting after clause (iii) the following new clause:
“(iv) for the portion of fiscal year 2014 before April 1, 2014, of \$2,500,000.”.

(d) **ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.**—Subsection (d)(2) of such section 119, as so amended, is amended—

- (1) in clause (ii), by striking “and” at the end;
- (2) in clause (iii), by striking the period at the end and inserting “; and”; and
- (3) by inserting after clause (iii) the following new clause:
“(iv) for the portion of fiscal year 2014 before April 1, 2014, of \$2,500,000.”.

TITLE II—OTHER HEALTH PROVISIONS

SEC. 1201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) **EXTENSION.**—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “December 2013” and inserting “March 2014”.

(b) **EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.**—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

- (1) in paragraph (2)—
 - (A) in subparagraph (S), by striking “and” after the semicolon;

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(B) in subparagraph (T), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(U) for the period that begins on January 1, 2014, and ends on March 31, 2014, the total allocation amount is \$200,000,000.”.

SEC. 1202. TEMPORARY EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)) are each amended by striking “December 31, 2013” and inserting “March 31, 2014”.

SEC. 1203. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c)(1)(A) of the Social Security Act (42 U.S.C. 701(c)(1)(A)) is amended—

(1) in clause (ii), by striking at the end “and”;

(2) in clause (iii), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following new clause:

“(iv) \$2,500,000 for the portion of fiscal year 2014 before April 1, 2014.”.

SEC. 1204. DELAY OF REDUCTIONS TO MEDICAID DSH ALLOTMENTS.

(a) **IN GENERAL.**—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i), by striking “2014” and inserting “2016”; and

(B) in clause (ii)—

(i) by striking subclauses (I) and (II);

(ii) by redesignating subclauses (III) through (VII) as subclauses (I) through (V), respectively; and

(iii) in subclause (I) (as redesignated by clause (ii)), by striking “\$600,000,000” and inserting “\$1,200,000,000”; and

(2) in paragraph (8)—

(A) by redesignating subparagraph (C) as subparagraph (D);

(B) by inserting after subparagraph (B) the following new subparagraph:

“(C) **FISCAL YEAR 2023.**—Only with respect to fiscal year 2023, the DSH allotment for a State, in lieu of the amount determined under paragraph (3) for the State for that year, shall be equal to the DSH allotment for the State for fiscal year 2022, as determined under subparagraph (B), increased, subject to subparagraphs (B) and (C) of paragraph (3), and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for fiscal year 2022.”; and

(C) in subparagraph (D) (as redesignated by subparagraph (A)), by striking “fiscal year 2022” and inserting “fiscal year 2023”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective as of October 1, 2013.

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SEC. 1205. REALIGNMENT OF THE MEDICARE SEQUESTER FOR FISCAL YEAR 2023.

Paragraph (6) (relating to implementing direct spending reductions, as redesignated by section 101(d)(2)(C), and as amended by section 101(c), of the Bipartisan Budget Act of 2013) of section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a) is amended by adding at the end the following new subparagraph:

“(C) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2023 shall be applied to such payments so that—

“(i) with respect to the first 6 months in which such order is effective for such fiscal year, the payment reduction shall be 2.90 percent; and

“(ii) with respect to the second 6 months in which such order is so effective for such fiscal year, the payment reduction shall be 1.11 percent.”.

SEC. 1206. PAYMENT FOR INPATIENT SERVICES IN LONG-TERM CARE HOSPITALS (LTCHS).

(a) ESTABLISHMENT OF CRITERIA FOR APPLICATION OF SITE NEUTRAL PAYMENT.—

(1) IN GENERAL.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following:

“(6) APPLICATION OF SITE NEUTRAL IPPS PAYMENT RATE IN CERTAIN CASES.—

“(A) GENERAL APPLICATION OF SITE NEUTRAL IPPS PAYMENT AMOUNT FOR DISCHARGES FAILING TO MEET APPLICABLE CRITERIA.—

“(i) IN GENERAL.—For a discharge in cost reporting periods beginning on or after October 1, 2015, except as provided in clause (ii) and subparagraph (C), payment under this title to a long-term care hospital for inpatient hospital services shall be made at the applicable site neutral payment rate (as defined in subparagraph (B)).

“(ii) EXCEPTION FOR CERTAIN DISCHARGES MEETING CRITERIA.—Clause (i) shall not apply (and payment shall be made to a long-term care hospital without regard to this paragraph) for a discharge if—

“(I) the discharge meets the ICU criterion under clause (iii) or the ventilator criterion under clause (iv); and

“(II) the discharge does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation.

“(iii) INTENSIVE CARE UNIT (ICU) CRITERION.—

“(I) IN GENERAL.—The criterion specified in this clause (in this paragraph referred to as the ‘ICU criterion’), for a discharge from a long-term care hospital, is that the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital that included at least

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3 days in an intensive care unit (ICU), as determined by the Secretary.

“(II) DETERMINING ICU DAYS.—In determining intensive care unit days under subclause (I), the Secretary shall use data from revenue center codes 020x or 021x (or such successor codes as the Secretary may establish).

“(iv) VENTILATOR CRITERION.—The criterion specified in this clause (in this paragraph referred to as the ‘ventilator criterion’), for a discharge from a long-term care hospital, is that—

“(I) the stay in the long-term care hospital ending with such discharge was immediately preceded by a discharge from a stay in a subsection (d) hospital; and

“(II) the individual discharged was assigned to a Medicare-Severity-Long-Term-Care-Diagnosis-Related-Group (MS-LTC-DRG) based on the receipt of ventilator services of at least 96 hours.

“(B) APPLICABLE SITE NEUTRAL PAYMENT RATE DEFINED.—

“(i) IN GENERAL.—In this paragraph, the term ‘applicable site neutral payment rate’ means—

“(I) for discharges in cost reporting periods beginning during fiscal year 2016 or fiscal year 2017, the blended payment rate specified in clause (iii); and

“(II) for discharges in cost reporting periods beginning during fiscal year 2018 or a subsequent fiscal year, the site neutral payment rate (as defined in clause (ii)).

“(ii) SITE NEUTRAL PAYMENT RATE DEFINED.—In this paragraph, the term ‘site neutral payment rate’ means the lower of—

“(I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or

“(II) 100 percent of the estimated cost for the services involved.

“(iii) BLENDED PAYMENT RATE.—The blended payment rate specified in this clause, for a long-term care hospital for inpatient hospital services for a discharge, is comprised of—

“(I) half of the site neutral payment rate (as defined in clause (ii)) for the discharge; and

“(II) half of the payment rate that would otherwise be applicable to such discharge without regard to this paragraph, as determined by the Secretary.

“(C) LIMITING PAYMENT FOR ALL HOSPITAL DISCHARGES TO SITE NEUTRAL PAYMENT RATE FOR HOSPITALS FAILING TO MEET APPLICABLE LTCH DISCHARGE THRESHOLDS.—

“(i) NOTICE OF LTCH DISCHARGE PAYMENT PERCENTAGE.—For cost reporting periods beginning during or after fiscal year 2016, the Secretary shall inform each

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long-term care hospital of its LTCH discharge payment percentage (as defined in clause (iv)) for such period.

“(ii) LIMITATION.—For cost reporting periods beginning during or after fiscal year 2020, if the Secretary determines for a long-term care hospital that its LTCH discharge payment percentage for the period is not at least 50 percent—

“(I) the Secretary shall inform the hospital of such fact; and

“(II) subject to clause (iii), for all discharges in the hospital in each succeeding cost reporting period, the payment amount under this subsection shall be the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital.

“(iii) PROCESS FOR REINSTATEMENT.—The Secretary shall establish a process whereby a long-term care hospital may seek to and have the provisions of subsection (II) of clause (ii) discontinued with respect to that hospital.

“(iv) LTCH DISCHARGE PAYMENT PERCENTAGE.—In this subparagraph, the term ‘LTCH discharge payment percentage’ means, with respect to a long-term care hospital for a cost reporting period beginning during or after fiscal year 2020, the ratio (expressed as a percentage) of—

“(I) the number of discharges for such hospital and period for which payment is not made at the site neutral payment rate, to

“(II) the total number of discharges for such hospital and period.

“(D) INCLUSION OF SUBSECTION (D) PUERTO RICO HOSPITALS.—In this paragraph, any reference in this paragraph to a subsection (d) hospital shall be deemed to include a reference to a subsection (d) Puerto Rico hospital.”.

(2) MEDPAC STUDY AND REPORT ON IMPACT OF CHANGES.—

(A) STUDY.—The Medicare Payment Assessment Commission shall examine the effect of applying section 1886(m)(6) of the Social Security Act, as added by the amendment made by paragraph (1), on—

(i) the quality of patient care in long-term care hospitals;

(ii) the use of hospice care and post-acute care settings;

(iii) different types of long-term care hospitals; and

(iv) the growth in Medicare spending for services in such hospitals.

(B) REPORT.—Not later than June 30, 2019, the Commission shall submit to Congress a report on such study. The Commission shall include in such report such recommendations for changes in the application of such section as the Commission deems appropriate as well as the impact of the application of such section on the need to continue applying the 25 percent rule described under sections 412.534 and 412.536 of title 42, Code of Federal Regulations.

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(3) CALCULATION OF LENGTH OF STAY EXCLUDING CASES PAID ON A SITE NEUTRAL BASIS.—

(A) IN GENERAL.—For discharges occurring in cost reporting periods beginning on or after October 1, 2015, subject to subparagraph (B), in calculating the length of stay requirement applicable to a long-term care hospital or satellite facility under section 1886(d)(1)(B)(iv)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)(I)) and section 1861(ccc)(2) of such Act (42 U.S.C. 1395x(ccc)(2)), the Secretary of Health and Human Services shall exclude the following:

(i) SITE NEUTRAL PAYMENT.—Any patient for whom payment is made at the site neutral payment rate (as defined in section 1886(m)(6)(B)(ii)) of such Act, as added by paragraph (1).

(ii) MEDICARE ADVANTAGE.—Any patient for whom payment is made under a Medicare Advantage plan under part C of title XVIII of such Act.

(B) LIMITATION ON CONVERTING SUBSECTION (D) HOSPITALS.—Subparagraph (A) shall not apply to a hospital that is classified as of December 10, 2013, as a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) for purposes of determining whether the requirements of section 1886(d)(1)(B)(iv)(I) or 1861(ccc)(2) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv)(I), 1395x(ccc)(2)) are met.

(b) EXTENSION OF CERTAIN LTCH PAYMENT RULES AND MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.—

(1) EXTENSION OF CERTAIN PAYMENT RULES.—

(A) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—Paragraph (2)(C) of section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(a) and 10312(a) of Public Law 111–148, is amended by striking “5-year period” and inserting “9-year period”.

(B) 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT; MAKING THE GRANDFATHERED EXEMPTION FOR LONG-TERM CARE HOSPITALS PERMANENT.—Section 114(c)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(a) and 10312(a) of Public Law 111–148, is amended—

(i) in the matter preceding subparagraph (A), by striking “for a 5-year period”; and

(ii) in subparagraph (A), by inserting “for a 9-year period,” before “section 412.536”.

(C) REPORT ASSESSING CONTINUED SUSPENSION OF 25 PERCENT RULE.—Not later than 1 year before the end of the 9-year period referred to in section 114(c)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by subparagraph (B), the Secretary of Health and Human Services shall submit to Congress a report on the need for any further extensions (or modifications of the extensions) of the 25 percent rule described in sections 412.534 and 412.536 of title 42, Code of Federal Regulations, particularly taking

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into account the application of section 1886(m)(6) of the Social Security Act, as added by subsection (a)(1).

(2) EXTENSION OF MORATORIUM ON ESTABLISHMENT OF AND INCREASE IN BEDS FOR LTCHS.—Section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(b) and 10312(b) of Public Law 111–148, is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting after “5-year period” the following: “(and for the period beginning January 1, 2015, and ending September 30, 2017)”; and

(B) by adding at the end the following new paragraph:

“(6) LIMITATION ON APPLICATION OF EXCEPTIONS.—Paragraphs (2) and (3) shall not apply during the period beginning January 1, 2015, and ending September 30, 2017.”

(c) ADDITIONAL QUALITY MEASURE.—Section 1886(m)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(m)(5)(D)) is amended by adding at the end the following new clause:

“(iv) ADDITIONAL QUALITY MEASURES.—Not later than October 1, 2015, the Secretary shall establish a functional status quality measure for change in mobility among inpatients requiring ventilator support.”

(d) REVIEW OF TREATMENT OF CERTAIN LTCHS.—

(1) EVALUATION.—As part of the annual rulemaking for fiscal year 2015 or fiscal year 2016 to carry out the payment rates under subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall evaluate both the payment rates and regulations governing hospitals which are classified under subclause (II) of subsection (d)(1)(B)(iv) of such section.

(2) ADJUSTMENT AUTHORITY.—Based upon such evaluation, the Secretary may adjust payment rates under subsection (b)(3) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) for a hospital so classified (such as payment based upon the TEFRA-payment model) and may adjust the regulations governing such hospitals, including applying the regulations governing hospitals which are classified under clause (I) of subsection (d)(1)(B) of such section.

Speaker of the House of Representatives.

*Vice President of the United States and
President of the Senate.*



August 28, 2017

3:39 pm
Supplemental B.EF.I.1.c

PUBLIC LAW 113-93—APR. 1, 2014

PROTECTING ACCESS TO MEDICARE ACT
OF 2014

Public Law 113–93
113th Congress

An Act

Apr. 1, 2014
[H.R. 4302]

Protecting Access
to Medicare Act
of 2014.

42 USC 1305
note.

To amend the Social Security Act to extend Medicare payments to physicians and other provisions of the Medicare and Medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Protecting Access to Medicare Act of 2014”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE EXTENDERS

- Sec. 101. Physician payment update.
- Sec. 102. Extension of work GPCI floor.
- Sec. 103. Extension of therapy cap exceptions process.
- Sec. 104. Extension of ambulance add-ons.
- Sec. 105. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.
- Sec. 106. Extension of the Medicare-dependent hospital (MDH) program.
- Sec. 107. Extension for specialized Medicare Advantage plans for special needs individuals.
- Sec. 108. Extension of Medicare reasonable cost contracts.
- Sec. 109. Extension of funding for quality measure endorsement, input, and selection.
- Sec. 110. Extension of funding outreach and assistance for low-income programs.
- Sec. 111. Extension of two-midnight rule.
- Sec. 112. Technical changes to Medicare LTCH amendments.

TITLE II—OTHER HEALTH PROVISIONS

- Sec. 201. Extension of the qualifying individual (QI) program.
- Sec. 202. Temporary extension of transitional medical assistance (TMA).
- Sec. 203. Extension of Medicaid and CHIP express lane option.
- Sec. 204. Extension of special diabetes program for type 1 diabetes and for Indians.
- Sec. 205. Extension of abstinence education.
- Sec. 206. Extension of personal responsibility education program (PREP).
- Sec. 207. Extension of funding for family-to-family health information centers.
- Sec. 208. Extension of health workforce demonstration project for low-income individuals.
- Sec. 209. Extension of maternal, infant, and early childhood home visiting programs.
- Sec. 210. Pediatric quality measures.
- Sec. 211. Delay of effective date for Medicaid amendments relating to beneficiary liability settlements.
- Sec. 212. Delay in transition from ICD–9 to ICD–10 code sets.
- Sec. 213. Elimination of limitation on deductibles for employer-sponsored health plans.
- Sec. 214. GAO report on the Children’s Hospital Graduate Medical Education Program.
- Sec. 215. Skilled nursing facility value-based purchasing.
- Sec. 216. Improving Medicare policies for clinical diagnostic laboratory tests.

- Sec. 217. Revisions under the Medicare ESRD prospective payment system.
- Sec. 218. Quality incentives for computed tomography diagnostic imaging and promoting evidence-based care.
- Sec. 219. Using funding from Transitional Fund for Sustainable Growth Rate (SGR) Reform.
- Sec. 220. Ensuring accurate valuation of services under the physician fee schedule.
- Sec. 221. Medicaid DSH.
- Sec. 222. Realignment of the Medicare sequester for fiscal year 2024.
- Sec. 223. Demonstration programs to improve community mental health services.
- Sec. 224. Assisted outpatient treatment grant program for individuals with serious mental illness.
- Sec. 225. Exclusion from PAYGO scorecards.

TITLE I—MEDICARE EXTENDERS

SEC. 101. PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended—

(1) in paragraph (15)—

(A) in the heading, by striking “JANUARY THROUGH MARCH OF”;

(B) in subparagraph (A), by striking “for the period beginning on January 1, 2014, and ending on March 31, 2014”; and

(C) in subparagraph (B)—

(i) in the heading, by striking “REMAINING PORTION OF 2014 AND”; and

(ii) by striking “the period beginning on April 1, 2014, and ending on December 31, 2014, and for”; and

(2) by adding at the end the following new paragraph:
“(16) UPDATE FOR JANUARY THROUGH MARCH OF 2015.—

“(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on March 31, 2015, the update to the single conversion factor shall be 0.0 percent.

“(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2015 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on April 1, 2015, and ending on December 31, 2015, and for 2016 and subsequent years as if subparagraph (A) had never applied.”.

Time periods.

SEC. 102. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “April 1, 2014” and inserting “April 1, 2015”.

SEC. 103. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (5)(A), in the first sentence, by striking “March 31, 2014” and inserting “March 31, 2015”; and

(2) in paragraph (6)(A)—

(A) by striking “March 31, 2014” and inserting “March 31, 2015”; and

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(B) by striking “2012, 2013, or the first three months of 2014” and inserting “2012, 2013, 2014, or the first three months of 2015”.

SEC. 104. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended by striking “April 1, 2014” and inserting “April 1, 2015” each place it appears.

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended, in the first sentence, by striking “April 1, 2014” and inserting “April 1, 2015”.

SEC. 105. EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking “in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years” and inserting “in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years”;

(2) in subparagraph (C)(i), by striking “fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before” and inserting “fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),” each place it appears; and

(3) in subparagraph (D), by striking “fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014,” and inserting “fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),”.

SEC. 106. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking “April 1, 2014” and inserting “April 1, 2015”; and

(2) in clause (ii)(II), by striking “April 1, 2014” and inserting “April 1, 2015”.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “April 1, 2014” and inserting “April 1, 2015”; and

(B) in clause (iv), by striking “through fiscal year 2013 and the portion of fiscal year 2014 before April 1, 2014” and inserting “through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015”.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking “through the first 2 quarters of fiscal year 2014” and inserting “through the first 2 quarters of fiscal year 2015”.

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SEC. 107. EXTENSION FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w-28(f)(1)) is amended by striking “2016” and inserting “2017”.

SEC. 108. EXTENSION OF MEDICARE REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking “January 1, 2015” and inserting “January 1, 2016”.

SEC. 109. EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended—

(1) by inserting “(1)” before “For purposes”; and

(2) by adding at the end the following new paragraph:

“(2) For purposes of carrying out this section and section 1890A (other than subsections (e) and (f)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, to the Centers for Medicare & Medicaid Services Program Management Account of \$5,000,000 for fiscal year 2014 and \$15,000,000 for the first 6 months of fiscal year 2015. Amounts transferred under the preceding sentence shall remain available until expended.”.

SEC. 110. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) **ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.**—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b-3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act Public Law 111-148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112-240), and section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113-67), is amended—

(1) in clause (iii), by striking “and” at the end;

(2) by striking clause (iv); and

(3) by adding at the end the following new clauses:

“(iv) for fiscal year 2014, of \$7,500,000; and

“(v) for the portion of fiscal year 2015 before April 1, 2015, of \$3,750,000.”.

(b) **ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.**—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking “and” at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

“(iv) for fiscal year 2014, of \$7,500,000; and

“(v) for the portion of fiscal year 2015 before April 1, 2015, of \$3,750,000.”.

(c) **ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.**—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking “and” at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

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“(iv) for fiscal year 2014, of \$5,000,000; and

“(v) for the portion of fiscal year 2015 before April 1, 2015, of \$2,500,000.”.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking “and” at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

“(iv) for fiscal year 2014, of \$5,000,000; and

“(v) for the portion of fiscal year 2015 before April 1, 2015, of \$2,500,000.”.

42 USC 1395ddd
note.

SEC. 111. EXTENSION OF TWO-MIDNIGHT RULE.

(a) CONTINUATION OF CERTAIN MEDICAL REVIEW ACTIVITIES.—The Secretary of Health and Human Services may continue medical review activities described in the notice entitled “Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013”, posted on the Internet website of the Centers for Medicare & Medicaid Services, through the first 6 months of fiscal year 2015 for such additional hospital claims as the Secretary determines appropriate.

Time period.

(b) LIMITATION.—The Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors under section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) for inpatient claims with dates of admission October 1, 2013, through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services (as defined in section 1861(u) of such Act (42 U.S.C. 1395x(u))).

SEC. 112. TECHNICAL CHANGES TO MEDICARE LTCH AMENDMENTS.

(a) IN GENERAL.—Subclauses (I) and (II) of section 1886(m)(6)(C)(iv) of the Social Security Act (42 U.S.C. 1395ww(m)(6)(C)(iv)) are each amended by striking “discharges” and inserting “Medicare fee-for-service discharges”.

(b) MMSEA CORRECTION.—Section 114(d) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by sections 3106(b) and 10312(b) of Public Law 111-148 and by section 1206(b)(2) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113-67), is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “January 1, 2015,” and inserting “on the date of the enactment of paragraph (7) of this subsection”;

(2) in paragraph (6), by striking “January 1, 2015,” and inserting “on the date of the enactment of paragraph (7) of this subsection”; and

(3) by adding at the end the following new paragraph:

“(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that—

“(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph;

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“(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least 10 percent of the estimated cost of the project (or, if less, \$2,500,000); or

“(C) has obtained an approved certificate of need in a State where one is required on or before such date of enactment.”.

(c) **ADDITIONAL AMENDMENTS.**—Section 1206(a) of the Pathway for SGR Reform Act of 2013 (division B of Public Law 113-67) is amended—

(1) in paragraph (2)(A), by striking “Assessment” and inserting “Advisory”; and

(2) in paragraph (3)(B), by striking “shall not apply to a hospital that is classified as of December 10, 2013, as a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B))” and inserting “shall only apply to a hospital that is classified as of December 10, 2013, as a long-term care hospital (as defined in section 1861(ccc) of the Social Security Act, 42 U.S.C. 1395x(ccc))”.

42 USC 1395ww
note.

(d) **EFFECTIVE DATE.**—The amendments made by this section are effective as of the date of the enactment of this Act.

42 USC 1395ww
note.

TITLE II—OTHER HEALTH PROVISIONS

SEC. 201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) **EXTENSION.**—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “March 2014” and inserting “March 2015”.

(b) **EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.**—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u-3(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (T), by striking “and” at the end;

(B) in subparagraph (U)—

(i) by striking “March 31, 2014” and inserting “September 30, 2014”; and

(ii) by striking “\$200,000,000.” and inserting “\$485,000,000.”; and

(C) by adding at the end the following new subparagraphs:

Time periods.

“(V) for the period that begins on October 1, 2014, and ends on December 31, 2014, the total allocation amount is \$300,000,000; and

“(W) for the period that begins on January 1, 2015, and ends on March 31, 2015, the total allocation amount is \$250,000,000.”; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking “or (T)” and inserting “(T), or (V)”.

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SEC. 202. TEMPORARY EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)) are each amended by striking “March 31, 2014” and inserting “March 31, 2015”.

SEC. 203. EXTENSION OF MEDICAID AND CHIP EXPRESS LANE OPTION.

Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking “September 30, 2014” and inserting “September 30, 2015”.

SEC. 204. EXTENSION OF SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES AND FOR INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c-2(b)(2)(C)) is amended by striking “2014” and inserting “2015”.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c-3(c)(2)(C)) is amended by striking “2014” and inserting “2015”.

SEC. 205. EXTENSION OF ABSTINENCE EDUCATION.

Subsections (a) and (d) of section 510 of the Social Security Act (42 U.S.C. 710) are each amended by striking “2014” and inserting “2015”.

SEC. 206. EXTENSION OF PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP).

Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(1) in paragraphs (1)(A) and (4)(A) of subsection (a), by striking “2014” and inserting “2015” each place it appears;

(2) in subsection (a)(4)(B)(i), by striking “and 2014” and inserting “2014, and 2015”; and

(3) in subsection (f), by striking “2014” and inserting “2015”.

SEC. 207. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c)(1)(A) of the Social Security Act (42 U.S.C. 701(c)(1)(A)) is amended—

(1) in clause (iii), by striking at the end “and”;

(2) in clause (iv), by striking the period at the end and inserting a semicolon and by moving the margin to align with the margin for clause (iii); and

(3) by adding at the end the following new clauses:

“(v) \$2,500,000 for the portion of fiscal year 2014 on or after April 1, 2014; and

“(vi) \$2,500,000 for the portion of fiscal year 2015 before April 1, 2015.”.

SEC. 208. EXTENSION OF HEALTH WORKFORCE DEMONSTRATION PROJECT FOR LOW-INCOME INDIVIDUALS.

Section 2008(c)(1) of the Social Security Act (42 U.S.C. 1397g(c)(1)) is amended by striking “2014” and inserting “2015”.

SEC. 209. EXTENSION OF MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Section 511(j) of the Social Security Act (42 U.S.C. 711(j)) is amended—

(1) in paragraph (1)—

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(A) by striking “and” at the end of subparagraph (D);
 (B) by striking the period at the end of subparagraph (E) and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(F) for the period beginning on October 1, 2014, and ending on March 31, 2015, an amount equal to the amount provided in subparagraph (E).”; and
 (2) in paragraphs (2) and (3), by inserting “(or portion of a fiscal year)” after “for a fiscal year” each place it appears.

Time period.

SEC. 210. PEDIATRIC QUALITY MEASURES.

(a) CONTINUATION OF FUNDING FOR PEDIATRIC QUALITY MEASURES FOR IMPROVING THE QUALITY OF CHILDREN’S HEALTH CARE.—Section 1139B(e) of the Social Security Act (42 U.S.C. 1320b–9b(e)) is amended by adding at the end the following: “Of the funds appropriated under this subsection, not less than \$15,000,000 shall be used to carry out section 1139A(b).”.

(b) ELIMINATION OF RESTRICTION ON MEDICAID QUALITY MEASUREMENT PROGRAM.—Section 1139B(b)(5)(A) of the Social Security Act (42 U.S.C. 1320b–9b(b)(5)(A)) is amended by striking “The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based measures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A).”.

SEC. 211. DELAY OF EFFECTIVE DATE FOR MEDICAID AMENDMENTS RELATING TO BENEFICIARY LIABILITY SETTLEMENTS.

Effective as if included in the enactment of the Bipartisan Budget Act of 2013 (Public Law 113–67), section 202(c) of such Act is amended by striking “October 1, 2014” and inserting “October 1, 2016”.

42 USC 1396a
note.

SEC. 212. DELAY IN TRANSITION FROM ICD-9 TO ICD-10 CODE SETS.

The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.

SEC. 213. ELIMINATION OF LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED HEALTH PLANS.

(a) IN GENERAL.—Section 1302(c) of the Patient Protection and Affordable Care Act (Public Law 111–148; 42 U.S.C. 18022(c)) is amended—

(1) by striking paragraph (2); and

(2) in paragraph (4)(A), by striking “paragraphs (1)(B)(i) and (2)(B)(i)” and inserting “paragraph (1)(B)(i)”.

(b) CONFORMING AMENDMENT.—Section 2707(b) of the Public Health Service Act (42 U.S.C. 300gg–6(b)) is amended by striking “paragraphs (1) and (2)” and inserting “paragraph (1)”.

(c) EFFECTIVE DATE.—The amendments made by this Act shall be effective as if included in the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148).

42 USC 300gg–6
note.

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SEC. 214. GAO REPORT ON THE CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION PROGRAM.

Evaluation.

(a) **IN GENERAL.**—In the case that the Children's Hospital GME Support Reauthorization Act of 2013 is enacted into law, the Comptroller General of the United States shall, not later than November 30, 2017, conduct an independent evaluation, and submit to the appropriate committees of Congress a report, concerning the implementation of section 340E(h) of the Public Health Service Act, as added by section 3 of the Children's Hospital GME Support Reauthorization Act of 2013.

(b) **CONTENT.**—The report described in subsection (a) shall review and assess each of the following, with respect to hospitals receiving payments under such section 340E(h) during the period of fiscal years 2015 through 2017:

(1) The number and type of such hospitals that applied for such payments.

(2) The number and type of such hospitals receiving such payments.

(3) The amount of such payments awarded to such hospitals.

(4) How such hospitals used such payments.

(5) The impact of such payments on—

(A) the number of pediatric providers; and

(B) health care needs of children.

SEC. 215. SKILLED NURSING FACILITY VALUE-BASED PURCHASING.

(a) **IN GENERAL.**—Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

“(g) **SKILLED NURSING FACILITY READMISSION MEASURE.**—

Deadline.

“(1) **READMISSION MEASURE.**—Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).

Deadline.

“(2) **RESOURCE USE MEASURE.**—Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.

“(3) **MEASURE ADJUSTMENTS.**—When specifying the measures under paragraphs (1) and (2), the Secretary shall devise a methodology to achieve a high level of reliability and validity, especially for skilled nursing facilities with a low volume of readmissions.

“(4) **PRE-RULEMAKING PROCESS (MEASURE APPLICATION PARTNERSHIP PROCESS).**—The application of the provisions of section 1890A shall be optional in the case of a measure specified under paragraph (1) and a measure specified under paragraph (2).

Effective date.

“(5) **FEEDBACK REPORTS TO SKILLED NURSING FACILITIES.**—Beginning October 1, 2016, and every quarter thereafter, the Secretary shall provide confidential feedback reports to skilled nursing facilities on the performance of such facilities with respect to a measure specified under paragraph (1) or (2).

“(6) **PUBLIC REPORTING OF SKILLED NURSING FACILITIES.**—

Procedures.
Web posting.

“(A) **IN GENERAL.**—Subject to subparagraphs (B) and (C), the Secretary shall establish procedures for making available to the public by posting on the Nursing Home

Compare Medicare website (or a successor website) described in section 1819(i) information on the performance of skilled nursing facilities with respect to a measure specified under paragraph (1) and a measure specified under paragraph (2).

“(B) OPPORTUNITY TO REVIEW.—The procedures under subparagraph (A) shall ensure that a skilled nursing facility has the opportunity to review and submit corrections to the information that is to be made public with respect to the facility prior to such information being made public.

“(C) TIMING.—Such procedures shall provide that the information described in subparagraph (A) is made publicly available beginning not later than October 1, 2017.

“(7) NON-APPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the ‘Paperwork Reduction Act of 1995’) shall not apply to this subsection.”

(b) VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES.—Section 1888 of the Social Security Act (42 U.S.C. 1395yy), as amended by subsection (a), is further amended by adding at the end the following new subsection:

“(h) SKILLED NURSING FACILITY VALUE-BASED PURCHASING PROGRAM.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a skilled nursing facility value-based purchasing program (in this subsection referred to as the ‘SNF VBP Program’) under which value-based incentive payments are made in a fiscal year to skilled nursing facilities.

“(B) PROGRAM TO BEGIN IN FISCAL YEAR 2019.—The SNF VBP Program shall apply to payments for services furnished on or after October 1, 2018.

Applicability.

“(2) APPLICATION OF MEASURES.—

“(A) IN GENERAL.—The Secretary shall apply the measure specified under subsection (g)(1) for purposes of the SNF VBP Program.

“(B) REPLACEMENT.—For purposes of the SNF VBP Program, the Secretary shall apply the measure specified under (g)(2) instead of the measure specified under (g)(1) as soon as practicable.

“(3) PERFORMANCE STANDARDS.—

“(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to the measure applied under paragraph (2) for a performance period for a fiscal year.

“(B) HIGHER OF ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement. In calculating the SNF performance score under paragraph (4), the Secretary shall use the higher of either improvement or achievement.

“(C) TIMING.—The Secretary shall establish and announce the performance standards established under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

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Assessment.

“(4) SNF PERFORMANCE SCORE.—

“(A) IN GENERAL.—The Secretary shall develop a methodology for assessing the total performance of each skilled nursing facility based on performance standards established under paragraph (3) with respect to the measure applied under paragraph (2). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ‘SNF performance score’) for each skilled nursing facility for each such performance period.

“(B) RANKING OF SNF PERFORMANCE SCORES.—The Secretary shall, for the performance period for each fiscal year, rank the SNF performance scores determined under subparagraph (A) from low to high.

“(5) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—With respect to a skilled nursing facility, based on the ranking under paragraph (4)(B) for a performance period for a fiscal year, the Secretary shall increase the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility (and after application of paragraph (6)) for services furnished by such facility during such fiscal year by the value-based incentive payment amount under subparagraph (B).

“(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for services furnished by a skilled nursing facility in a fiscal year shall be equal to the product of—

“(i) the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to such skilled nursing facility for such services furnished by the skilled nursing facility during such fiscal year; and

“(ii) the value-based incentive payment percentage specified under subparagraph (C) for the skilled nursing facility for such fiscal year.

“(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

“(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a skilled nursing facility for a fiscal year which may include a zero percentage.

“(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each skilled nursing facility for a fiscal year under clause (i), the Secretary shall ensure that—

“(I) such percentage is based on the SNF performance score of the skilled nursing facility provided under paragraph (4) for the performance period for such fiscal year;

“(II) the application of all such percentages in such fiscal year results in an appropriate distribution of value-based incentive payments under subparagraph (B) such that—

“(aa) skilled nursing facilities with the highest rankings under paragraph (4)(B) receive the highest value-based incentive payment amounts under subparagraph (B);

“(bb) skilled nursing facilities with the lowest rankings under paragraph (4)(B) receive the lowest value-based incentive payment amounts under subparagraph (B); and

“(cc) in the case of skilled nursing facilities in the lowest 40 percent of the ranking under paragraph (4)(B), the payment rate under subparagraph (A) for services furnished by such facility during such fiscal year shall be less than the payment rate for such services for such fiscal year that would otherwise apply under subsection (e)(4)(G) without application of this subsection; and

“(III) the total amount of value-based incentive payments under this paragraph for all skilled nursing facilities in such fiscal year shall be greater than or equal to 50 percent, but not greater than 70 percent, of the total amount of the reductions to payments for such fiscal year under paragraph (6), as estimated by the Secretary.

“(6) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—The Secretary shall reduce the adjusted Federal per diem rate determined under subsection (e)(4)(G) otherwise applicable to a skilled nursing facility for services furnished by such facility during a fiscal year (beginning with fiscal year 2019) by the applicable percent (as defined in subparagraph (B)). The Secretary shall make such reductions for all skilled nursing facilities in the fiscal year involved, regardless of whether or not the skilled nursing facility has been determined by the Secretary to have earned a value-based incentive payment under paragraph (5) for such fiscal year.

“(B) APPLICABLE PERCENT.—For purposes of subparagraph (A), the term ‘applicable percent’ means, with respect to fiscal year 2019 and succeeding fiscal years, 2 percent.

“(7) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—

Under the SNF VBP Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each skilled nursing facility of the adjustments to payments to the skilled nursing facility for services furnished by such facility during the fiscal year under paragraphs (5) and (6).

Deadline.

“(8) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (5) and the payment reduction under paragraph (6) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a skilled nursing facility under this section in a subsequent fiscal year.

Applicability.

“(9) PUBLIC REPORTING.—

“(A) SNF SPECIFIC INFORMATION.—The Secretary shall make available to the public, by posting on the Nursing Home Compare Medicare website (or a successor website) described in section 1819(i) in an easily understandable format, information regarding the performance of individual skilled nursing facilities under the SNF VBP Program, with respect to a fiscal year, including—

Web posting.

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“(i) the SNF performance score of the skilled nursing facility for such fiscal year; and

“(ii) the ranking of the skilled nursing facility under paragraph (4)(B) for the performance period for such fiscal year.

“(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Nursing Home Compare Medicare website (or a successor website) described in section 1819(i) aggregate information on the SNF VBP Program, including—

“(i) the range of SNF performance scores provided under paragraph (4)(A); and

“(ii) the number of skilled nursing facilities receiving value-based incentive payments under paragraph (5) and the range and total amount of such value-based incentive payments.

“(10) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) The methodology used to determine the value-based incentive payment percentage and the amount of the value-based incentive payment under paragraph (5).

“(B) The determination of the amount of funding available for such value-based incentive payments under paragraph (5)(C)(ii)(III) and the payment reduction under paragraph (6).

“(C) The establishment of the performance standards under paragraph (3) and the performance period.

“(D) The methodology developed under paragraph (4) that is used to calculate SNF performance scores and the calculation of such scores.

“(E) The ranking determinations under paragraph (4)(B).

“(11) FUNDING FOR PROGRAM MANAGEMENT.—The Secretary shall provide for the one time transfer from the Federal Hospital Insurance Trust Fund established under section 1817 to the Centers for Medicare & Medicaid Services Program Management Account of—

“(A) for purposes of subsection (g)(2), \$2,000,000; and

“(B) for purposes of implementing this subsection, \$10,000,000.

Such funds shall remain available until expended.”.

(c) MEDPAC STUDY.—Not later than June 30, 2021, the Medicare Payment Advisory Commission shall submit to Congress a report that reviews the progress of the skilled nursing facility value-based purchasing program established under section 1888(h) of the Social Security Act, as added by subsection (b), and makes recommendations, as appropriate, on any improvements that should be made to such program. For purposes of the previous sentence, the Medicare Payment Advisory Commission shall consider any unintended consequences with respect to such skilled nursing facility value-based purchasing program and any potential adjustments to the readmission measure specified under section 1888(g)(1) of such Act, as added by subsection (a), for purposes of determining the effect of the socio-economic status of a beneficiary under the Medicare program under title XVIII of the Social Security Act

Deadline.
Reports.
Recommendations.

for the SNF performance score of a skilled nursing facility provided under section 1888(h)(4) of such Act, as added by subsection (b).

SEC. 216. IMPROVING MEDICARE POLICIES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1834 (42 U.S.C. 1395m) the following new section:

“SEC. 1834A. IMPROVING POLICIES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

42 USC
1395m–1.

“(a) REPORTING OF PRIVATE SECTOR PAYMENT RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT RATES.—

“(1) IN GENERAL.—Beginning January 1, 2016, and every 3 years thereafter (or, annually, in the case of reporting with respect to an advanced diagnostic laboratory test, as defined in subsection (d)(5)), an applicable laboratory (as defined in paragraph (2)) shall report to the Secretary, at a time specified by the Secretary, applicable information (as defined in paragraph (3)) for a data collection period (as defined in paragraph (4)) for each clinical diagnostic laboratory test that the laboratory furnishes during such period for which payment is made under this part.

Effective date.

“(2) DEFINITION OF APPLICABLE LABORATORY.—In this section, the term ‘applicable laboratory’ means a laboratory that, with respect to its revenues under this title, a majority of such revenues are from this section, section 1833(h), or section 1848. The Secretary may establish a low volume or low expenditure threshold for excluding a laboratory from the definition of applicable laboratory under this paragraph, as the Secretary determines appropriate.

“(3) APPLICABLE INFORMATION DEFINED.—

“(A) IN GENERAL.—In this section, subject to subparagraph (B), the term ‘applicable information’ means, with respect to a laboratory test for a data collection period, the following:

“(i) The payment rate (as determined in accordance with paragraph (5)) that was paid by each private payor for the test during the period.

“(ii) The volume of such tests for each such payor for the period.

“(B) EXCEPTION FOR CERTAIN CONTRACTUAL ARRANGEMENTS.—Such term shall not include information with respect to a laboratory test for which payment is made on a capitated basis or other similar payment basis during the data collection period.

“(4) DATA COLLECTION PERIOD DEFINED.—In this section, the term ‘data collection period’ means a period of time, such as a previous 12 month period, specified by the Secretary.

“(5) TREATMENT OF DISCOUNTS.—The payment rate reported by a laboratory under this subsection shall reflect all discounts, rebates, coupons, and other price concessions, including those described in section 1847A(c)(3).

“(6) ENSURING COMPLETE REPORTING.—In the case where an applicable laboratory has more than one payment rate for the same payor for the same test or more than one payment rate for different payors for the same test, the applicable laboratory shall report each such payment rate and the volume for

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Effective date.

the test at each such rate under this subsection. Beginning with January 1, 2019, the Secretary may establish rules to aggregate reporting with respect to the situations described in the preceding sentence.

“(7) CERTIFICATION.—An officer of the laboratory shall certify the accuracy and completeness of the information reported under this subsection.

“(8) PRIVATE PAYOR DEFINED.—In this section, the term ‘private payor’ means the following:

“(A) A health insurance issuer and a group health plan (as such terms are defined in section 2791 of the Public Health Service Act).

“(B) A Medicare Advantage plan under part C.

“(C) A medicaid managed care organization (as defined in section 1903(m)).

“(9) CIVIL MONEY PENALTY.—

Determination.

“(A) IN GENERAL.—If the Secretary determines that an applicable laboratory has failed to report or made a misrepresentation or omission in reporting information under this subsection with respect to a clinical diagnostic laboratory test, the Secretary may apply a civil money penalty in an amount of up to \$10,000 per day for each failure to report or each such misrepresentation or omission.

“(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

“(10) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a laboratory under this subsection is confidential and shall not be disclosed by the Secretary or a Medicare contractor in a form that discloses the identity of a specific payor or laboratory, or prices charged or payments made to any such laboratory, except—

“(A) as the Secretary determines to be necessary to carry out this section;

“(B) to permit the Comptroller General to review the information provided;

“(C) to permit the Director of the Congressional Budget Office to review the information provided; and

“(D) to permit the Medicare Payment Advisory Commission to review the information provided.

“(11) PROTECTION FROM PUBLIC DISCLOSURE.—A payor shall not be identified on information reported under this subsection. The name of an applicable laboratory under this subsection shall be exempt from disclosure under section 552(b)(3) of title 5, United States Code.

Deadline.
Notice.

“(12) REGULATIONS.—Not later than June 30, 2015, the Secretary shall establish through notice and comment rule-making parameters for data collection under this subsection.

“(b) PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—

“(1) USE OF PRIVATE PAYOR RATE INFORMATION TO DETERMINE MEDICARE PAYMENT RATES.—

“(A) IN GENERAL.—Subject to paragraph (3) and subsections (c) and (d), in the case of a clinical diagnostic laboratory test furnished on or after January 1, 2017, the

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payment amount under this section shall be equal to the weighted median determined for the test under paragraph (2) for the most recent data collection period.

“(B) APPLICATION OF PAYMENT AMOUNTS TO HOSPITAL LABORATORIES.—The payment amounts established under this section shall apply to a clinical diagnostic laboratory test furnished by a hospital laboratory if such test is paid for separately, and not as part of a bundled payment under section 1833(t).

“(2) CALCULATION OF WEIGHTED MEDIAN.—For each laboratory test with respect to which information is reported under subsection (a) for a data collection period, the Secretary shall calculate a weighted median for the test for the period, by arraying the distribution of all payment rates reported for the period for each test weighted by volume for each payor and each laboratory.

“(3) PHASE-IN OF REDUCTIONS FROM PRIVATE PAYOR RATE IMPLEMENTATION.—

“(A) IN GENERAL.—Payment amounts determined under this subsection for a clinical diagnostic laboratory test for each of 2017 through 2022 shall not result in a reduction in payments for a clinical diagnostic laboratory test for the year of greater than the applicable percent (as defined in subparagraph (B)) of the amount of payment for the test for the preceding year.

“(B) APPLICABLE PERCENT DEFINED.—In this paragraph, the term ‘applicable percent’ means—

“(i) for each of 2017 through 2019, 10 percent; and

“(ii) for each of 2020 through 2022, 15 percent.

“(C) NO APPLICATION TO NEW TESTS.—This paragraph shall not apply to payment amounts determined under this section for either of the following.

“(i) A new test under subsection (c).

“(ii) A new advanced diagnostic test (as defined in subsection (d)(5)) under subsection (d).

“(4) APPLICATION OF MARKET RATES.—

“(A) IN GENERAL.—Subject to paragraph (3), once established for a year following a data collection period, the payment amounts under this subsection shall continue to apply until the year following the next data collection period.

“(B) OTHER ADJUSTMENTS NOT APPLICABLE.—The payment amounts under this section shall not be subject to any adjustment (including any geographic adjustment, budget neutrality adjustment, annual update, or other adjustment).

“(5) SAMPLE COLLECTION FEE.—In the case of a sample collected from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, the nominal fee that would otherwise apply under section 1833(h)(3)(A) shall be increased by \$2.

“(c) PAYMENT FOR NEW TESTS THAT ARE NOT ADVANCED DIAGNOSTIC LABORATORY TESTS.—

“(1) PAYMENT DURING INITIAL PERIOD.—In the case of a clinical diagnostic laboratory test that is assigned a new or

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substantially revised HCPCS code on or after the date of enactment of this section, and which is not an advanced diagnostic laboratory test (as defined in subsection (d)(5)), during an initial period until payment rates under subsection (b) are established for the test, payment for the test shall be determined—

“(A) using cross-walking (as described in section 414.508(a) of title 42, Code of Federal Regulations, or any successor regulation) to the most appropriate existing test under the fee schedule under this section during that period; or

“(B) if no existing test is comparable to the new test, according to the gapfilling process described in paragraph (2).

“(2) GAPFILLING PROCESS DESCRIBED.—The gapfilling process described in this paragraph shall take into account the following sources of information to determine gapfill amounts, if available:

“(A) Charges for the test and routine discounts to charges.

“(B) Resources required to perform the test.

“(C) Payment amounts determined by other payors.

“(D) Charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant.

“(E) Other criteria the Secretary determines appropriate.

“(3) ADDITIONAL CONSIDERATION.—In determining the payment amount under crosswalking or gapfilling processes under this subsection, the Secretary shall consider recommendations from the panel established under subsection (f)(1).

“(4) EXPLANATION OF PAYMENT RATES.—In the case of a clinical diagnostic laboratory test for which payment is made under this subsection, the Secretary shall make available to the public an explanation of the payment rate for the test, including an explanation of how the criteria described in paragraph (2) and paragraph (3) are applied.

“(d) PAYMENT FOR NEW ADVANCED DIAGNOSTIC LABORATORY TESTS.—

“(1) PAYMENT DURING INITIAL PERIOD.—

“(A) IN GENERAL.—In the case of an advanced diagnostic laboratory test for which payment has not been made under the fee schedule under section 1833(h) prior to the date of enactment of this section, during an initial period of three quarters, the payment amount for the test for such period shall be based on the actual list charge for the laboratory test.

“(B) ACTUAL LIST CHARGE.—For purposes of subparagraph (A), the term ‘actual list charge’, with respect to a laboratory test furnished during such period, means the publicly available rate on the first day at which the test is available for purchase by a private payor.

“(2) SPECIAL RULE FOR TIMING OF INITIAL REPORTING.—With respect to an advanced diagnostic laboratory test described in paragraph (1)(A), an applicable laboratory shall initially be required to report under subsection (a) not later than the last day of the second quarter of the initial period under such paragraph.

Public
information.

Definition.

“(3) APPLICATION OF MARKET RATES AFTER INITIAL PERIOD.—Subject to paragraph (4), data reported under paragraph (2) shall be used to establish the payment amount for an advanced diagnostic laboratory test after the initial period under paragraph (1)(A) using the methodology described in subsection (b). Such payment amount shall continue to apply until the year following the next data collection period.

“(4) RECOUPMENT IF ACTUAL LIST CHARGE EXCEEDS MARKET RATE.—With respect to the initial period described in paragraph (1)(A), if, after such period, the Secretary determines that the payment amount for an advanced diagnostic laboratory test under paragraph (1)(A) that was applicable during the period was greater than 130 percent of the payment amount for the test established using the methodology described in subsection (b) that is applicable after such period, the Secretary shall recoup the difference between such payment amounts for tests furnished during such period.

Determination.

“(5) ADVANCED DIAGNOSTIC LABORATORY TEST DEFINED.—In this subsection, the term ‘advanced diagnostic laboratory test’ means a clinical diagnostic laboratory test covered under this part that is offered and furnished only by a single laboratory and not sold for use by a laboratory other than the original developing laboratory (or a successor owner) and meets one of the following criteria:

“(A) The test is an analysis of multiple biomarkers of DNA, RNA, or proteins combined with a unique algorithm to yield a single patient-specific result.

“(B) The test is cleared or approved by the Food and Drug Administration.

“(C) The test meets other similar criteria established by the Secretary.

“(e) CODING.—

“(1) TEMPORARY CODES FOR CERTAIN NEW TESTS.—

“(A) IN GENERAL.—The Secretary shall adopt temporary HCPCS codes to identify new advanced diagnostic laboratory tests (as defined in subsection (d)(5)) and new laboratory tests that are cleared or approved by the Food and Drug Administration.

“(B) DURATION.—

“(i) IN GENERAL.—Subject to clause (ii), the temporary code shall be effective until a permanent HCPCS code is established (but not to exceed 2 years).

“(ii) EXCEPTION.—The Secretary may extend the temporary code or establish a permanent HCPCS code, as the Secretary determines appropriate.

“(2) EXISTING TESTS.—Not later than January 1, 2016, for each existing advanced diagnostic laboratory test (as so defined) and each existing clinical diagnostic laboratory test that is cleared or approved by the Food and Drug Administration for which payment is made under this part as of the date of enactment of this section, if such test has not already been assigned a unique HCPCS code, the Secretary shall—

Deadline.

“(A) assign a unique HCPCS code for the test; and

“(B) publicly report the payment rate for the test.

Public information.

“(3) ESTABLISHMENT OF UNIQUE IDENTIFIER FOR CERTAIN TESTS.—For purposes of tracking and monitoring, if a laboratory or a manufacturer requests a unique identifier for an advanced

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diagnostic laboratory test (as so defined) or a laboratory test that is cleared or approved by the Food and Drug Administration, the Secretary shall utilize a means to uniquely track such test through a mechanism such as a HCPCS code or modifier.

“(f) INPUT FROM CLINICIANS AND TECHNICAL EXPERTS.—

Consultation.
Establishment.
Deadline.

“(1) IN GENERAL.—The Secretary shall consult with an expert outside advisory panel, established by the Secretary not later than July 1, 2015, composed of an appropriate selection of individuals with expertise, which may include molecular pathologists, researchers, and individuals with expertise in laboratory science or health economics, in issues related to clinical diagnostic laboratory tests, which may include the development, validation, performance, and application of such tests, to provide—

“(A) input on—

“(i) the establishment of payment rates under this section for new clinical diagnostic laboratory tests, including whether to use crosswalking or gapfilling processes to determine payment for a specific new test; and

“(ii) the factors used in determining coverage and payment processes for new clinical diagnostic laboratory tests; and

“(B) recommendations to the Secretary under this section.

“(2) COMPLIANCE WITH FACA.—The panel shall be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

“(3) CONTINUATION OF ANNUAL MEETING.—The Secretary shall continue to convene the annual meeting described in section 1833(h)(8)(B)(iii) after the implementation of this section for purposes of receiving comments and recommendations (and data on which the recommendations are based) as described in such section on the establishment of payment amounts under this section.

“(g) COVERAGE.—

“(1) ISSUANCE OF COVERAGE POLICIES.—

“(A) IN GENERAL.—A medicare administrative contractor shall only issue a coverage policy with respect to a clinical diagnostic laboratory test in accordance with the process for making a local coverage determination (as defined in section 1869(f)(2)(B)), including the appeals and review process for local coverage determinations under part 426 of title 42, Code of Federal Regulations (or successor regulations).

“(B) NO EFFECT ON NATIONAL COVERAGE DETERMINATION PROCESS.—This paragraph shall not apply to the national coverage determination process (as defined in section 1869(f)(1)(B)).

“(C) EFFECTIVE DATE.—This paragraph shall apply to coverage policies issued on or after January 1, 2015.

“(2) DESIGNATION OF ONE OR MORE MEDICARE ADMINISTRATIVE CONTRACTORS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—The Secretary may designate one or more (not to exceed 4) medicare administrative contractors to either establish coverage policies or establish coverage policies and process claims

for payment for clinical diagnostic laboratory tests, as determined appropriate by the Secretary.

“(h) IMPLEMENTATION.—

“(1) IMPLEMENTATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the establishment of payment amounts under this section.

“(2) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected under this section.

“(3) FUNDING.—For purposes of implementing this section, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, to the Centers for Medicare & Medicaid Services Program Management Account, for each of fiscal years 2014 through 2018, \$4,000,000, and for each of fiscal years 2019 through 2023, \$3,000,000. Amounts transferred under the preceding sentence shall remain available until expended.

“(i) TRANSITIONAL RULE.—During the period beginning on the date of enactment of this section and ending on December 31, 2016, with respect to advanced diagnostic laboratory tests under this part, the Secretary shall use the methodologies for pricing, coding, and coverage in effect on the day before such date of enactment, which may include cross-walking or gapfilling methods.”. Time period.

(b) CONFORMING AMENDMENTS.—

(1) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (1)(D)—

(i) by striking “(i) on the basis” and inserting “(i)(I) on the basis”;

(ii) in subclause (I), as added by clause (i), by striking “subsection (h)(1)” and inserting “subsection (h)(1) (for tests furnished before January 1, 2017)”;

(iii) by striking “or (ii)” and inserting “or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii)”;

(iv) in clause (ii), by striking “on the basis” and inserting “for tests furnished before January 1, 2017, on the basis”;

(B) in paragraph (2)(D)—

(i) by striking “(i) on the basis” and inserting “(i)(I) on the basis”;

(ii) in subclause (I), as added by clause (i), by striking “subsection (h)(1)” and inserting “subsection (h)(1) (for tests furnished before January 1, 2017)”;

(iii) by striking “or (ii)” and inserting “or (II) under section 1834A (for tests furnished on or after January 1, 2017), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such

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section or the amount of the charges billed for the tests, or (ii)”; and

(iv) in clause (ii), by striking “on the basis” and inserting “for tests furnished before January 1, 2017, on the basis”;

(C) in subsection (b)(3)(B), by striking “on the basis” and inserting “for tests furnished before January 1, 2017, on the basis”;

(D) in subsection (h)(2)(A)(i), by striking “and subject to” and inserting “and, for tests furnished before the date of enactment of section 1834A, subject to”;

(E) in subsection (h)(3), in the matter preceding subparagraph (A), by striking “fee schedules” and inserting “fee schedules (for tests furnished before January 1, 2017) or under section 1834A (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section”;

(F) in subsection (h)(6), by striking “In the case” and inserting “For tests furnished before January 1, 2017, in the case”; and

(G) in subsection (h)(7), in the first sentence—

(i) by striking “and (4)” and inserting “and (4) and section 1834A”; and

(ii) by striking “under this subsection” and inserting “under this part”.

(2) Section 1869(f)(2) of the Social Security Act (42 U.S.C. 1395ff(f)(2)) is amended by adding at the end the following new subparagraph:

“(C) LOCAL COVERAGE DETERMINATIONS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—For provisions relating to local coverage determinations for clinical diagnostic laboratory tests, see section 1834A(g).”

(c) GAO STUDY AND REPORT; MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—

(1) GAO STUDY AND REPORT ON IMPLEMENTATION OF NEW PAYMENT RATES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—

(A) STUDY.—The Comptroller General of the United States (in this subsection referred to as the “Comptroller General”) shall conduct a study on the implementation of section 1834A of the Social Security Act, as added by subsection (a). The study shall include an analysis of—

(i) payment rates paid by private payors for laboratory tests furnished in various settings, including—

(I) how such payment rates compare across settings;

(II) the trend in payment rates over time; and

(III) trends by private payors to move to alternative payment methodologies for laboratory tests; (ii) the conversion to the new payment rate for laboratory tests under such section;

(iii) the impact of such implementation on beneficiary access under title XVIII of the Social Security Act;

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(iv) the impact of the new payment system on laboratories that furnish a low volume of services and laboratories that specialize in a small number of tests;

(v) the number of new Healthcare Common Procedure Coding System (HCPCS) codes issued for laboratory tests;

(vi) the spending trend for laboratory tests under such title;

(vii) whether the information reported by laboratories and the new payment rates for laboratory tests under such section accurately reflect market prices;

(viii) the initial list price for new laboratory tests and the subsequent reported rates for such tests under such section;

(ix) changes in the number of advanced diagnostic laboratory tests and laboratory tests cleared or approved by the Food and Drug Administration for which payment is made under such section; and

(x) healthcare economic information on downstream cost impacts for such tests and decision making based on accepted methodologies.

(B) REPORT.—Not later than October 1, 2018, the Comptroller General shall submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the study under subparagraph (A), including recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—The Inspector General of the Department of Health and Human Services shall—

(A) publicly release an annual analysis of the top 25 laboratory tests by expenditures under title XVIII of the Social Security Act; and

(B) conduct analyses the Inspector General determines appropriate with respect to the implementation and effect of the new payment system for laboratory tests under section 1834A of the Social Security Act, as added by subsection (a).

Analysis.
42 USC 1395m-1
note.

Public
information.
Deadline.

SEC. 217. REVISIONS UNDER THE MEDICARE ESRD PROSPECTIVE PAYMENT SYSTEM.

(a) DELAY OF IMPLEMENTATION OF ORAL-ONLY POLICY.—Section 632(b)(1) of the American Taxpayer Relief Act of 2012 (42 U.S.C. 1395rr note) is amended—

(1) by striking “2016” and inserting “2024”; and

(2) by adding at the end the following new sentence: “Notwithstanding section 1881(b)(14)(A)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(A)(ii)), implementation of the policy described in the previous sentence shall be based on data from the most recent year available.”.

(b) MITIGATION OF THE APPLICATION OF ADJUSTMENT TO ESRD BUNDLED PAYMENT RATE TO ACCOUNT FOR CHANGES IN THE UTILIZATION OF CERTAIN DRUGS AND BIOLOGICALS.—

(1) IN GENERAL.—Section 1881(b)(14)(I) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(I)) is amended by inserting “and before January 1, 2015,” after “January 1, 2014.”

(2) MARKET BASKET.—Section 1881(b)(14)(F)(i) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)(i)) is amended—

(A) in subclause (I)—

(i) by striking “subclause (II)” and inserting “subclauses (II) and (III)”; and

(ii) by adding at the end the following new sentence: “In order to accomplish the purposes of subparagraph (I) with respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018.”;

(B) in subclause (II), by striking “For 2012” and inserting “Subject to subclause (III), for 2012”; and

(C) by adding at the end the following new subclause:

“(III) Notwithstanding subclauses (I) and (II), in order to accomplish the purposes of subparagraph (I) with respect to 2015, the increase factor described in subclause (I) for 2015 shall be 0.0 percent pursuant to the regulation issued by the Secretary on December 2, 2013, entitled ‘Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule’ (78 Fed. Reg. 72156).”.

(c) DRUG DESIGNATIONS.—As part of the promulgation of annual rule for the Medicare end stage renal disease prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) for calendar year 2016, the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall establish a process for—

(1) determining when a product is no longer an oral-only drug; and

(2) including new injectable and intravenous products into the bundled payment under such system.

(d) QUALITY MEASURES RELATED TO CONDITIONS TREATED BY ORAL-ONLY DRUGS UNDER THE ESRD QUALITY INCENTIVE PROGRAM.—Section 1881(h)(2) of the Social Security Act (42 U.S.C. 1395rr(h)(2)) is amended—

(1) in subparagraph (A)—

(A) in clause (ii), by striking “and” at the end;

(B) by redesignating clause (iii) as clause (iv); and

(C) by inserting after clause (ii) the following new clause:

“(iii) for 2016 and subsequent years, measures described in subparagraph (E)(i); and”;

(2) in subparagraph (B)(i), by striking “(A)(iii)” and inserting “(A)(iv)”; and

(3) by adding at the end the following new subparagraph:

“(E) MEASURES SPECIFIC TO THE CONDITIONS TREATED WITH ORAL-ONLY DRUGS.—

“(i) IN GENERAL.—The measures described in this subparagraph are measures specified by the Secretary that are specific to the conditions treated with oral-

Process.
42 USC 1395rr
note.

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only drugs. To the extent feasible, such measures shall be outcomes-based measures.

“(ii) CONSULTATION.—In specifying the measures under clause (i), the Secretary shall consult with interested stakeholders.

“(iii) USE OF ENDORSED MEASURES.—

“(I) IN GENERAL.—Subject to subclause (I), any measures specified under clause (i) must have been endorsed by the entity with a contract under section 1890(a).

“(II) EXCEPTION.—If the entity with a contract under section 1890(a) has not endorsed a measure for a specified area or topic related to measures described in clause (i) that the Secretary determines appropriate, the Secretary may specify a measure that is endorsed or adopted by a consensus organization recognized by the Secretary that has expertise in clinical guidelines for kidney disease.”.

(e) AUDITS OF COST REPORTS OF ESRD PROVIDERS AS RECOMMENDED BY MEDPAC.—

42 USC 1395rr
note.

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct audits of Medicare cost reports beginning during 2012 for a representative sample of providers of services and renal dialysis facilities furnishing renal dialysis services.

(2) FUNDING.—For purposes of carrying out paragraph (1), the Secretary of Health and Human Services shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Services Program Management Account of \$18,000,000 for fiscal year 2014. Amounts transferred under this paragraph for a fiscal year shall be available until expended.

SEC. 218. QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY DIAGNOSTIC IMAGING AND PROMOTING EVIDENCE-BASED CARE.

(a) QUALITY INCENTIVES TO PROMOTE PATIENT SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOGRAPHY DIAGNOSTIC IMAGING.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(p) QUALITY INCENTIVES TO PROMOTE PATIENT SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOGRAPHY.—

“(1) QUALITY INCENTIVES.—In the case of an applicable computed tomography service (as defined in paragraph (2)) for which payment is made under an applicable payment system (as defined in paragraph (3)) and that is furnished on or after January 1, 2016, using equipment that is not consistent with the CT equipment standard (described in paragraph (4)), the payment amount for such service shall be reduced by the applicable percentage (as defined in paragraph (5)).

“(2) APPLICABLE COMPUTED TOMOGRAPHY SERVICES DEFINED.—In this subsection, the term ‘applicable computed tomography service’ means a service billed using diagnostic radiological imaging codes for computed tomography (identified

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as of January 1, 2014, by HCPCS codes 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574 (and any succeeding codes).

“(3) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term ‘applicable payment system’ means the following:

“(A) The technical component and the technical component of the global fee under the fee schedule established under section 1848(b).

“(B) The prospective payment system for hospital outpatient department services under section 1833(t).

Definition.

“(4) CONSISTENCY WITH CT EQUIPMENT STANDARD.—In this subsection, the term ‘not consistent with the CT equipment standard’ means, with respect to an applicable computed tomography service, that the service was furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled ‘Standard Attributes on CT Equipment Related to Dose Optimization and Management’. Through rule-making, the Secretary may apply successor standards.

“(5) APPLICABLE PERCENTAGE DEFINED.—In this subsection, the term ‘applicable percentage’ means—

“(A) for 2016, 5 percent; and

“(B) for 2017 and subsequent years, 15 percent.

“(6) IMPLEMENTATION.—

“(A) INFORMATION.—The Secretary shall require that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable computed tomography service was furnished that was not consistent with the CT equipment standard (described in paragraph (4)). Such information may be included on a claim and may be a modifier. Such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under section 1834(e) and hospitals under section 1865(a).

Verification.

“(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information described in subparagraph (A).”.

(2) CONFORMING AMENDMENTS.—

(A) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

“(20) NOT BUDGET NEUTRAL APPLICATION OF REDUCED EXPENDITURES RESULTING FROM QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—The Secretary shall not take into account the reduced expenditures that result from the application of section 1834(p) in making any budget neutrality adjustments this subsection.”.

(B) PHYSICIAN FEE SCHEDULE.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

“(VIII) REDUCED EXPENDITURES ATTRIBUTABLE TO APPLICATION OF QUALITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—Effective for fee schedules

Effective date.

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established beginning with 2016, reduced expenditures attributable to the application of the quality incentives for computed tomography under section 1834(p)".

(b) PROMOTING EVIDENCE-BASED CARE.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by subsection (a), is amended by adding at the end the following new subsection:

"(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

"(1) PROGRAM ESTABLISHED.—

"(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

"(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term 'appropriate use criteria' means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria shall be evidence-based.

"(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term 'applicable imaging service' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

"(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

"(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

"(iii) one or more of such mechanisms is available free of charge.

"(D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

"(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term 'ordering professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service.

"(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term 'furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service.

"(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

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Deadline.
Regulations.
Consultation.

“(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities.

“(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

“(i) have stakeholder consensus;

“(ii) are scientifically valid and evidence based;

and

“(iii) are based on studies that are published and reviewable by stakeholders.

Review.
Deadline.

“(C) REVISIONS.—The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rulemaking.

“(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criterion applies with respect to an applicable imaging service, the Secretary shall apply one or more applicable appropriate use criteria under this paragraph for the service.

“(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

“(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

“(i) IN GENERAL.—The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

“(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

“(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

“(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

“(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

“(III) Use of a clinical decision support mechanism established by the Secretary.

“(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

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“(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

“(ii) REQUIREMENTS.—The requirements described in this clause are the following:

“(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

“(II) In the case where there is more than one applicable appropriate use criterion specified under such paragraph for an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

“(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

“(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

“(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

“(VI) The mechanism meets privacy and security standards under applicable provisions of law.

“(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

“(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

Deadlines.

“(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

Publication.

“(ii) PERIODIC UPDATING OF LIST.—The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

“(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

“(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

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“(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

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Effective date.

“(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

“(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

“(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

“(ii) Information regarding—

“(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

“(II) whether the service ordered would not adhere to such criteria; or

“(III) whether such criteria was not applicable to the service ordered.

“(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

“(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

“(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

“(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

“(iii) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

“(D) APPLICABLE PAYMENT SYSTEM DEFINED.—In this subsection, the term ‘applicable payment system’ means the following:

“(i) The physician fee schedule established under section 1848(b).

“(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

“(iii) The ambulatory surgical center payment systems under section 1833(i).

“(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

Effective date.
Determination.

“(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent

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of the total number of ordering professionals who are outlier ordering professionals.

“(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

“(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

“(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

“(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

“(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

“(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

“(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

“(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that are ordered by an outlier ordering professional identified under paragraph (5).

Effective date.

“(B) APPROPRIATE USE CRITERIA IN PRIOR AUTHORIZATION.—In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

“(C) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

“(7) CONSTRUCTION.—Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.”

(2) CONFORMING AMENDMENT.—Section 1833(t)(16) of the Social Security Act (42 U.S.C. 1395l(t)(16)) is amended by adding at the end the following new subparagraph:

“(E) APPLICATION OF APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—For provisions relating to the application of appropriate use criteria for certain imaging services, see section 1834(q).”

(3) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that includes

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a description of the extent to which appropriate use criteria could be used for other services under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), such as radiation therapy and clinical diagnostic laboratory services.

SEC. 219. USING FUNDING FROM TRANSITIONAL FUND FOR SUSTAINABLE GROWTH RATE (SGR) REFORM.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking “\$2,300,000,000” and inserting “\$0”.

SEC. 220. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) **AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS’ SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—**

(1) **IN GENERAL.**—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraph:

“(M) **AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS’ SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—**

“(i) **COLLECTION OF INFORMATION.**—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

“(ii) **USE OF INFORMATION.**—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

“(iii) **TYPES OF INFORMATION.**—The types of information described in clauses (i) and (ii) may, at the Secretary’s discretion, include any or all of the following:

“(I) Time involved in furnishing services.

“(II) Amounts and types of practice expense inputs involved with furnishing services.

“(III) Prices (net of any discounts) for practice expense inputs, which may include paid invoice prices or other documentation or records.

“(IV) Overhead and accounting information for practices of physicians and other suppliers.

“(V) Any other element that would improve the valuation of services under this section.

“(iv) **INFORMATION COLLECTION MECHANISMS.**—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

“(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

“(II) Surgical logs, billing systems, or other practice or facility records.

“(III) Electronic health records.

“(IV) Any other mechanism determined appropriate by the Secretary.

“(v) TRANSPARENCY OF USE OF INFORMATION.—

“(I) IN GENERAL.—Subject to subclauses (II) and (III), if the Secretary uses information collected or obtained under this subparagraph in the determination of relative values under this subsection, the Secretary shall disclose the information source and discuss the use of such information in such determination of relative values through notice and comment rulemaking.

Notice.
Comments.

“(II) THRESHOLDS FOR USE.—The Secretary may establish thresholds in order to use such information, including the exclusion of information collected or obtained from eligible professionals who use very high resources (as determined by the Secretary) in furnishing a service.

“(III) DISCLOSURE OF INFORMATION.—The Secretary shall make aggregate information available under this subparagraph but shall not disclose information in a form or manner that identifies an eligible professional or a group practice, or information collected or obtained pursuant to a nondisclosure agreement.

“(vi) INCENTIVE TO PARTICIPATE.—The Secretary may provide for such payments under this part to an eligible professional that submits such solicited information under this subparagraph as the Secretary determines appropriate in order to compensate such eligible professional for such submission. Such payments shall be provided in a form and manner specified by the Secretary.

“(vii) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to information collected or obtained under this subparagraph.

“(viii) DEFINITION OF ELIGIBLE PROFESSIONAL.—In this subparagraph, the term ‘eligible professional’ has the meaning given such term in subsection (k)(3)(B).

“(ix) FUNDING.—For purposes of carrying out this subparagraph, in addition to funds otherwise appropriated, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.”

(2) LIMITATION ON REVIEW.—Section 1848(i)(1) of the Social Security Act (42 U.S.C. 1395w-4(i)(1)) is amended—

(A) in subparagraph (D), by striking “and” at the end;

(B) in subparagraph (E), by striking the period at the end and inserting “, and”; and

(C) by adding at the end the following new subparagraph:

“(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).”

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(b) **AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.**—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

“(N) **AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.**—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).”.

(c) **REVISED AND EXPANDED IDENTIFICATION OF POTENTIALLY MISVALUED CODES.**—Section 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

“(ii) **IDENTIFICATION OF POTENTIALLY MISVALUED CODES.**—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

“(I) Codes that have experienced the fastest growth.

“(II) Codes that have experienced substantial changes in practice expenses.

“(III) Codes that describe new technologies or services within an appropriate time period (such as 3 years) after the relative values are initially established for such codes.

“(IV) Codes which are multiple codes that are frequently billed in conjunction with furnishing a single service.

“(V) Codes with low relative values, particularly those that are often billed multiple times for a single treatment.

“(VI) Codes that have not been subject to review since implementation of the fee schedule.

“(VII) Codes that account for the majority of spending under the physician fee schedule.

“(VIII) Codes for services that have experienced a substantial change in the hospital length of stay or procedure time.

“(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

“(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

“(XI) Codes for which there may be anomalies in relative values within a family of codes.

“(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

“(XIII) Codes with high intra-service work per unit of time.

“(XIV) Codes with high practice expense relative value units.

“(XV) Codes with high cost supplies.

“(XVI) Codes as determined appropriate by the Secretary.”.

(d) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

“(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2017 through 2020, the following shall apply:

Applicability.

“(i) DETERMINATION OF NET REDUCTION IN EXPENDITURES.—For each year, the Secretary shall determine the estimated net reduction in expenditures under the fee schedule under this section with respect to the year as a result of adjustments to the relative values established under this paragraph for misvalued codes.

“(ii) BUDGET NEUTRAL REDISTRIBUTION OF FUNDS IF TARGET MET AND COUNTING OVERAGES TOWARDS THE TARGET FOR THE SUCCEEDING YEAR.—If the estimated net reduction in expenditures determined under clause (i) for the year is equal to or greater than the target for the year—

“(I) reduced expenditures attributable to such adjustments shall be redistributed for the year in a budget neutral manner in accordance with subparagraph (B)(ii)(II); and

“(II) the amount by which such reduced expenditures exceeds the target for the year shall be treated as a reduction in expenditures described in clause (i) for the succeeding year, for purposes of determining whether the target has or has not been met under this subparagraph with respect to that year.

“(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2017.

“(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

“(I) the target for the year; and

“(II) the estimated net reduction in expenditures determined under clause (i) for the year.

“(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.”.

(2) CONFORMING AMENDMENT.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

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11:27 am

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Effective date,
Time period,

“(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2017, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).”

(e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—

(1) IN GENERAL.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w-4(c)) is amended by adding at the end the following new paragraph:

Effective date.

“(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2017, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.”

(2) CONFORMING AMENDMENTS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended—

(A) in subparagraph (B)(ii)(I), by striking “subclause (II)” and inserting “subclause (II) and paragraph (7)”; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking “provisions of subparagraph (B)(ii)(II)” and inserting “provisions of subparagraph (B)(ii)(II) and paragraph (7)”; and

(ii) by striking “under subparagraph (B)(ii)(II)” and inserting “under subparagraph (B)(ii)(I)”.

(f) AUTHORITY TO SMOOTH RELATIVE VALUES WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)) is amended—

(1) in each of clauses (i) and (iii), by striking “the service” and inserting “the service or group of services” each place it appears; and

(2) in the first sentence of clause (ii), by inserting “or group of services” before the period.

(g) GAO STUDY AND REPORT ON RELATIVE VALUE SCALE UPDATE COMMITTEE.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the “Comptroller General”) shall conduct a study of the processes used by the Relative Value Scale Update Committee (RUC) to provide recommendations to the Secretary of Health and Human Services regarding relative values for specific services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1).

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

(1) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w-4(e)) is amended by adding at the end the following new paragraph:

“(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

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“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and notwithstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following: Applicability.

“(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an ‘MSA’), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

“(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

“(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

“(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such year shall be equal to the sum of the following: Time period.

“(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

“(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

“(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

“(I) for 2017, is $\frac{5}{6}$; and

“(II) for each succeeding year, is the old weighting factor described in this clause for the previous year minus $\frac{1}{6}$.

“(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

“(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply. Applicability.

“(D) TRANSITION AREA DEFINED.—In this paragraph, the term ‘transition area’ means each of the following fee schedule areas for 2013:

“(i) The rest-of-State payment locality.

“(ii) Payment locality 3.

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Effective date.

“(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.”.

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w-4(j)(2)) is amended by striking “The term” and inserting “Except as provided in subsection (e)(6)(D), the term”.

42 USC 1395w-4
note.
Public
information.

(i) DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—The Secretary of Health and Human Services shall make publicly available the information used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register, v. 77, n. 222, November 16, 2012, pages 68891–69380 under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

SEC. 221. MEDICAID DSH.

(a) MODIFICATIONS OF REDUCTIONS TO ALLOTMENTS.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i), by striking “2016 through 2020” and inserting “2017 through 2024”; and

(B) in clause (ii), by striking subclauses (I) through (IV), and inserting the following:

- “(I) \$1,800,000,000 for fiscal year 2017;
- “(II) \$4,700,000,000 for fiscal year 2018;
- “(III) \$4,700,000,000 for fiscal year 2019;
- “(IV) \$4,700,000,000 for fiscal year 2020;
- “(V) \$4,800,000,000 for fiscal year 2021;
- “(VI) \$5,000,000,000 for fiscal year 2022;
- “(VII) \$5,000,000,000 for fiscal year 2023; and
- “(VIII) \$4,400,000,000 for fiscal year 2024.”;

and

(2) by striking paragraph (8) and inserting the following:

“(8) CALCULATION OF DSH ALLOTMENTS AFTER REDUCTIONS PERIOD.—The DSH allotment for a State for fiscal years after fiscal year 2024 shall be calculated under paragraph (3) without regard to paragraph (7).”.

(b) MACPAC REVIEW AND REPORT.—Section 1900(b)(6) of the Social Security Act (42 U.S.C. 1396(b)(6)) is amended—

(1) by striking “MACPAC shall consult” and inserting the following:

“(A) IN GENERAL.—MACPAC shall consult”; and

(2) by adding at the end the following:

“(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

“(i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

“(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

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“(I) Data relating to changes in the number of uninsured individuals.

“(II) Data relating to the amount and sources of hospitals’ uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

“(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services.

“(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

“(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

“(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.”.

SEC. 222. REALIGNMENT OF THE MEDICARE SEQUESTER FOR FISCAL YEAR 2024.

Paragraph (6) (relating to implementing direct spending reductions) of section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a) is amended by adding at the end the following new subparagraph:

“(D) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2024 shall be applied to such payments so that—

“(i) with respect to the first 6 months in which such order is effective for such fiscal year, the payment reduction shall be 4.0 percent; and

“(ii) with respect to the second 6 months in which such order is so effective for such fiscal year, the payment reduction shall be 0.0 percent.”.

Applicability.

SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES.

42 USC 1396a note.

(a) **CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—**

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Deadline.

(1) **PUBLICATION.**—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

(2) **REQUIREMENTS.**—The criteria published under this subsection shall include criteria with respect to the following:

(A) **STAFFING.**—Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

(B) **AVAILABILITY AND ACCESSIBILITY OF SERVICES.**—Availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.

(C) **CARE COORDINATION.**—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics.

(D) **SCOPE OF SERVICES.**—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d).

Deadline.
Applicability.

(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(c) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d).

Deadline.

128 STAT. 1080

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(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

Certification.

(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

(d) DEMONSTRATION PROGRAMS.—

Deadline.

(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

(2) APPLICATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

(i) The target Medicaid population to be served under the demonstration program.

(ii) A list of participating certified community behavioral health clinics.

(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

(vi) Such other information as the Secretary may require relating to the demonstration program including with respect to determining the soundness of the proposed prospective payment system.

(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Not more than 8 States shall be selected for 2-year demonstration programs under this subsection.

(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible

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for medical assistance under the State Medicaid program;

(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

(B) FEDERAL MATCHING PERCENTAGE.—The Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished—

(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

(C) LIMITATIONS.—

(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

(I) that are described in the demonstration program application in accordance with paragraph (2)(iv);

(II) for which payment is available under the State Medicaid program; and

(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

(I) for inpatient care, residential treatment, room and board expenses, or any other non-

ambulatory services, as determined by the Secretary; or

(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(6) **WAIVER OF STATEWIDENESS REQUIREMENT.**—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be necessary to conduct demonstration programs in accordance with the requirements of this subsection.

(7) **ANNUAL REPORTS.**—

(A) **IN GENERAL.**—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

(B) **RECOMMENDATIONS.**—Not later than December 31, 2021, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.

(e) **DEFINITIONS.**—In this section:

(1) **FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.**—The terms “Federally-qualified health center services”, “Federally-qualified health center”, “rural health clinic services”, and “rural health clinic” have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

(2) **ENHANCED FMAP.**—The term “enhanced FMAP” has the meaning given that term in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b)) but without regard to the second and third sentences of that section.

(3) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(4) **STATE.**—The term “State” has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(f) **FUNDING.**—

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128 STAT. 1083

(1) **IN GENERAL.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

(A) for purposes of carrying out subsections (a), (b), and (d)(7), \$2,000,000 for fiscal year 2014; and

(B) for purposes of awarding planning grants under subsection (c), \$25,000,000 for fiscal year 2016.

(2) **AVAILABILITY.**—Funds appropriated under paragraph (1) shall remain available until expended.

SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

42 USC 290aa
note.

(a) **IN GENERAL.**—The Secretary shall establish a 4-year pilot program to award not more than 50 grants each year to eligible entities for assisted outpatient treatment programs for individuals with serious mental illness.

(b) **CONSULTATION.**—The Secretary shall carry out this section in consultation with the Director of the National Institute of Mental Health, the Attorney General of the United States, the Administrator of the Administration for Community Living, and the Administrator of the Substance Abuse and Mental Health Services Administration.

(c) **SELECTING AMONG APPLICANTS.**—The Secretary—

(1) may only award grants under this section to applicants that have not previously implemented an assisted outpatient treatment program; and

(2) shall evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patient.

(d) **USE OF GRANT.**—An assisted outpatient treatment program funded with a grant awarded under this section shall include—

(1) evaluating the medical and social needs of the patients who are participating in the program;

(2) preparing and executing treatment plans for such patients that—

(A) include criteria for completion of court-ordered treatment; and

(B) provide for monitoring of the patient's compliance with the treatment plan, including compliance with medication and other treatment regimens;

(3) providing for such patients case management services that support the treatment plan;

(4) ensuring appropriate referrals to medical and social service providers;

(5) evaluating the process for implementing the program to ensure consistency with the patient's needs and State law; and

(6) measuring treatment outcomes, including health and social outcomes such as rates of incarceration, health care utilization, and homelessness.

(e) **REPORT.**—Not later than the end of each of fiscal years 2016, 2017, and 2018, the Secretary shall submit a report to the appropriate congressional committees on the grant program under this section. Each such report shall include an evaluation of the following:

Evaluation.

128 STAT. 1084

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(1) Cost savings and public health outcomes such as mortality, suicide, substance abuse, hospitalization, and use of services.

(2) Rates of incarceration by patients.

(3) Rates of homelessness among patients.

(4) Patient and family satisfaction with program participation.

(f) DEFINITIONS.—In this section:

(1) The term “assisted outpatient treatment” means medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a State or local court to order such treatment.

(2) The term “eligible entity” means a county, city, mental health system, mental health court, or any other entity with authority under the law of the State in which the grantee is located to implement, monitor, and oversee assisted outpatient treatment programs.

(3) The term “Secretary” means the Secretary of Health and Human Services.

(g) FUNDING.—

Determination.

(1) AMOUNT OF GRANTS.—A grant under this section shall be in an amount that is not more than \$1,000,000 for each of fiscal years 2015 through 2018. Subject to the preceding sentence, the Secretary shall determine the amount of each grant based on the population of the area, including estimated patients, to be served under the grant.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$15,000,000 for each of fiscal years 2015 through 2018.

SEC. 225. EXCLUSION FROM PAYGO SCORECARDS.

(a) STATUTORY PAY-AS-YOU-GO SCORECARDS.—The budgetary effects of this Act shall not be entered on either PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010.

(b) SENATE PAYGO SCORECARDS.—The budgetary effects of this Act shall not be entered on any PAYGO scorecard maintained for purposes of section 201 of S. Con. Res. 21 (110th Congress).

Approved April 1, 2014.

LEGISLATIVE HISTORY—H.R. 4302:

CONGRESSIONAL RECORD, Vol. 160 (2014):

Mar. 27, considered and passed House.

Mar. 31, considered and passed Senate.





AUG 28 '17 PM 3:39

SUPPLEMENTAL #1

August 28, 2017

11:27 am
Supplemental B.OD.D.2

April 5, 2017

Mr. Mark Kelly, Administrator
Regional One Health Extended Care Hospital
890 Madison Avenue, 4th Floor
Memphis, TN 38103

RE: Fire Safety Licensure Survey

Dear Mr. Kelly:

The West of Health Care Facilities completed a fire safety licensure survey on **January 11, 2017**. Based on the revisit completed **March 31, 2017**, we are accepting your plan of correction and found your facility to be in substantial compliance with all participation requirements as of **February 25, 2017**.

If you have any questions, please contact at West Tennessee Regional Office at 731-984-9684.

Sincerely,

Kathy Zeigler

Kathy Zeigler, RN
Public Health Nurse Consultant 2


KZ/RW

Supplemental-#2 -Original-

Regional One Extended
Care Hospital

CN1708-025

ANDERSON & BAKER
An Association of Attorneys
2021 RICHARD JONES ROAD, SUITE 120
NASHVILLE, TENNESSEE 37215-2874

SUPPLEMENTAL #2

August 30, 2017

11:47 pm

08/30/17 11:48 AM

ROBERT A. ANDERSON
Direct: 615-383-3332
Facsimile: 615-383-3480

E. GRAHAM BAKER, JR.
Direct: 615-370-3380
Facsimile: 615-221-0080

August 30, 2017

Phillip Earhart, Health Services Examiner
State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Hand-Delivered

Re: Certificate of Need Application CN1708-025
Regional One Extended Care Hospital
Supplemental Responses #2

Dear Mr. Earhart:

Please find attached the Applicant's responses to your second set of Supplemental Questions.
Please contact me if you have any additional questions.

Sincerely,


E. Graham Baker, Jr.

Encl: As Noted

1. Section B, Need, Item A Section C, Item 1.a. (Long Term Care Hospital Beds-A. Need 1.)

Please confirm the following table to determine LTACH bed need (1).

	Population		0.5 LTACH bed X (10,000 population)		Current licensed beds	Net Need	
	2017	2019	2017	2019	2017	2017	2019
Shelby County (Proposed Service Area)	964,804	970,212	48 beds	49 beds	93 beds	(45) bed surplus	(44) bed surplus

Response: First, the population figure the HSDA has provided for Shelby County in 2019 is incorrect. The number should be 975,626 (according to Health Statistics, TDOH). The projected population for Shelby County in 2018 is 970,212. That said, utilizing the correct population projection for 2019 will not alter the LTACH bed need for 2019, as stated in the chart above.

Second, the above chart provided by the HSDA misstates the project's service area to be limited to Shelby County, alone. If the HSDA wants to consider only Shelby County as the service area for this project, there is a surplus of 44 beds in 2019 as noted in the chart above.

However, the original submission contained the following statement regarding the project's service area:

"As the service being provided is very specialized, patients originate from a wide geographic area. The facility's existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant."

The Applicant maintains the project's service area to be much larger than Shelby County, Tennessee, as explained in the application. Only about half (53%) of the Applicant's patients originated from Shelby County in 2015, and only 63% of our patients originated from Tennessee, as stated in the quote above. Our primary service area is as originally stated, including Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas.

2. Section B, Need, Item E

Your response is noted. Please complete the following table:

LTACH Utilization Trends-2013-2015

Facility	Licensed Beds	2013 Admissions	2014 Admissions	2015 Admissions	2013 Average Length of Stay	2014 Average Length of Stay	2015 Average Length of Stay
Baptist	30	286	259	250	34.5	32.8	33.4
Methodist	36	426	435	424	26.4	27.0	27.1
Select Specialty	39	448	422	265	28.6	32.5	50.5
Regional MED	24	n/a	63	181	n/a	27.2	37.9
Total	129	1160	1179	1120	29.2	30.3	35.8

Source: LTACH JAR, 2013-2015

Response: The above chart is completed. Please note that Regional MED LTACH was not open in 2013, and was open for only part of 2014.

Your response is noted. However, the 2015 % occupancy for Regional Med appears incorrect in the table submitted in Supplemental #1 on page 14. Please confirm the following table with the corrected 2015 licensed occupancy for Regional Med.

LTACH Utilization Trends-2013-2015

Facility	Licensed Beds	2013 Patient Days	2014 Patient Days	2015 Patient Days	'13- '15 % change	2013 % Occupancy	2014 % Occupancy	2015 % Occupancy
Baptist	30	9,855	8,499	8,354	-15.2%	90.0%	77.2%	76.3%
Methodist	36	11,228	11,752	11,485	+2.3%	85.4%	89.4%	87.4%
Select Specialty	39	12,811	13,724	13,388	+4.5%	90.0%	96.4%	94.0%
Regional MED	24	0	1,711	6,854	n/a	0.00%	19.5%	78.2%
Total	129	33,894	35,686	40,081	+18.25%	88.4%*	75.7%	85.1%

Source: LTACH JAR, 2013-2015

*based on 105 beds, since Regional Med was not in existence in 2013

Response: There was a typo in the original submission. The 2015 patient days for Regional MED LTACH was 6,854, not 9,854. The occupancy rate is correct as noted. The above chart has been corrected.

ADDITIONAL INFORMATION REGARDING AREA LTACHs:

Due to the unique and specialized nature of the services provided, LTACHs draw from a wide geographic area. All of the LTACHs in West Tennessee are in Shelby County, and the Applicant's primary service area consists of Shelby County and coterminous counties in Mississippi and Arkansas. A question has arisen regarding LTACHs geographically close to Memphis. There are no LTACHs in Tennessee between Memphis and Nashville. The closest LTACHs to Memphis are out of state, as follows:

In searching the American Hospital Directory, there are only three LTACHs within 75 miles of zip code 38103 (the Applicant's zip code), and all three are in Memphis (Shelby County):

Baptist Memorial Restorative Care Hospital (30 beds);
Regional One Health Extended Care Hospital (24 beds); and
Select Specialty Hospital – Memphis (39 beds).

Expanding the search to 100 miles, there is only one additional LTACH in addition to the above which is Advanced Care Hospital of White County (27 beds in Searcy, Arkansas).

Extended to 120 miles, there is only one additional LTACH in addition to the above which is AMG Specialty Hospital of Greenwood (40 beds in Greenwood, Mississippi).

Extending to 150 miles of zip code 38103, the **total** list of LTACHs is as follows:

Baptist Memorial Restorative Care Hospital (30 beds in Memphis);
Regional One Health Extended Care Hospital (24 beds in Memphis);
Select Specialty Hospital – Memphis (39 beds in Memphis);
Advanced Care Hospital of White County (27 beds in Searcy, Arkansas);
AMG Specialty Hospital of Greenwood (40 beds in Greenwood, Mississippi);
Allegiance Specialty Hospital of Greenville (39 beds in Greenville, Mississippi);
Baptist Health Extended Care Hospital (55 beds in Little Rock, Arkansas); and
Cornerstone Hospital Little Rock (40 beds in Little Rock, Arkansas).

August 30, 2017

11:47 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Regional One Extended Care Facility, CN1708-025

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.


Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30th day of AUGUST, 20 17, witness my hand at office in the County of Davidson, State of Tennessee.


NOTARY PUBLIC

My commission expires 3/3/20

HF-0043

Revised 7/02

